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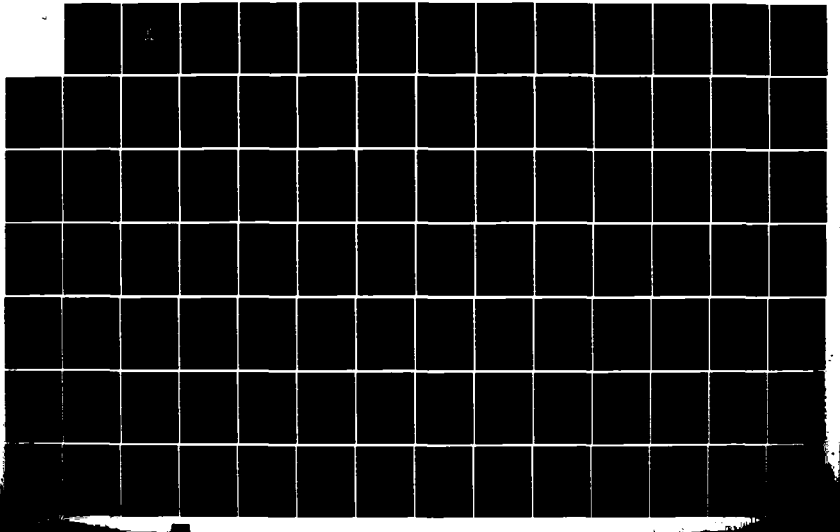

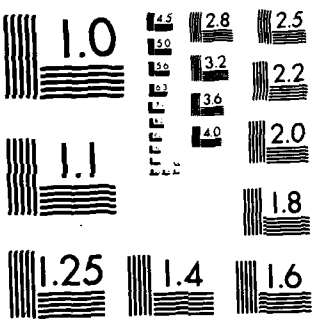

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CURRENT TRENDS
in
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9 - 13 December 1974

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Army Psychology, community psychology, human relations center concept, organizational development, paraprofessinal counseling, aviator performance, command consultation, drug use behaviors, Army field feeding, military police performance, parent effectiveness training, neuropsychological assessment, and professional standards

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The Proceedings document the 1974 symposium presentations and group reports. Presentations dealt with: the human relations center concept, aviator performance, alcohol and drug control officer counselors, career progession, Army field feeding, military police performance in interpersonal crisis situations, professional standards, health care regulations, neuropsychological testing, procurement of Army uniformed psychologists, division psychology, and Army consultation. Task reports were from committees on: internship training, and career development

and planning for applied psychologists.

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DEPARTMENT OF THE ARMY
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WASHINGTON, D.C. 20314

REPLY TO ATTENTION OF:

DASG-HCC-H

CURRENT TRENDS IN ARMY
MEDICAL DEPARTMENT PSYCHOLOGY

This five day short course had fifty-eight registered participants although there were only 35 centrally funded spaces. Approximately fifty additional hospital personnel from FAMC and Denver Mental Health agencies attended one or more of the presentations by civilian speakers.

The participants in work groups addressed themselves to a number of significant issues impacting on AMEDD psychology and the behavioral sciences including the development of health care delivery systems to appropriately and effectively utilize the increasingly scarce behavioral science resources in the Army. Other issues addressed were the training of functional professionals, selection and training of psychologists in the military, changing roles of psychologists, impact on AMEDD psychology of the loss of the Graduate Student Program.

During the paper presentations and the accompanying lively discussions the current professional activities of psychologists were presented in detail: child and family treatment programs, organizational development programs, training as an effective means of treatment, utilization and training of functional professionals, role of the division psychologist, human resources training at the Army War College, research psychologists in Human Engineering Laboratories, psychological aspects of Army field feeding, skills training with chaplains, nurses and MPs.

The work groups which developed during this conference will continue to address their respective issues and to come up with viable programs for consideration. It is noteworthy that the work groups developed into task oriented groups.

Richard E. Hartzell

RICHARD E. HARTZELL
LTC, MSC
Psychology Consultant
Course Director

FITZSIMONS ARMY MEDICAL CENTER

Major General James A. Wier, MC, Commanding

CURRENT TRENDS

IN

ARMY MEDICAL DEPARTMENT PSYCHOLOGY

9 - 13 December 1974

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MONDAY
9 December 1974

0845 Welcome Address
MG James A. Wier, MC
Commanding General, Fitzsimons Army Medical Center
Denver, Colorado

0900 Theme of Conference
LTC Richard E. Hartzell, MSC
Psychology Consultant
Office of the Surgeon General
Headquarters, Department of the Army
Washington, D.C.

1000 Professional Models of Practice for Psychologists
Nelson F. Jones, Ph.D.
Professor of Psychology & Director of Clinical Training
University of Denver
Denver, Colorado

1300 Critical Issues for AMEDD Psychology
LTC Richard E. Hartzell

1415 Formation of Work Groups
Work groups will form to address the issues raised by the Psychology Consultant. Individuals will choose their group based on the issue that holds the most interest for them. The pre-selected leaders will facilitate the group's work.

TUESDAY
10 December 1974

0800 Work Groups
The work groups will continue discussion of issues with the intent of laying the base for future action by psychologists and of providing recommendations for action by the Psychology Consultant.

Afternoon Session - Quade Conference Center

1300 APA Standards for the Delivery of Psychological Services
COL (Retired) Jerry H. Clark, Ph.D.
Psychologist (Private Practice)
Santa Barbara, California

1430 Models for Intervention in Family Systems
Dane G. Prugh, M.D.
Professor of Psychiatry and Pediatrics
University of Colorado School of Medicine
Denver, Colorado

WEDNESDAY
11 December 1974

0800 Scientific and Professional Papers and Symposia Chairman:
MAJ E.R. Worthington
MEDDAC
Ft Polk, Louisiana

Individuals wishing to present papers o[illegible]ganize other presentations will have arranged [illegible] so with the chairman. Presentations will c[illegible] the full range of AMEDD psychology interests. Using the "free university" concept, participants will choose those sessions they wish to attend. Emphasis will be on maximizing mutual interests of presenters and participants as well as stimulating full and active participation of all concerned.

THURSDAY
12 December 1974

0800 Scientific and Professional Papers and Symposia
(continued)

1100 Work Groups
Work groups will prepare brief reports for the afternoon session.

Afternoon Session - Quade Conference Center

1300 Work Group Presentations
Spokesmen from the work groups will briefly present relevant observations, recommendations, and plans for the future to the entire assembly.

1415 Applications of Biofeedback in Clinical Research & Therapy
Thomas H. Budzynski, Ph.D.
Assistant Clinical Professor
Department of Psychiatry
University of Colorado School of Medicine &
Clinical Director, SARUS Institute
Denver, Colorado

FRIDAY
13 December 1974

0800 Work Group Presentations
(continue)

0930 Summary
LTC Richard E. Hartzell

1000 Individual Conferences With the Psychology Consultant

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CPT James W. Futterer

Use of Paraprofessional Counseling With USMC Cadets During First Summer Camp - Philosophy, Selection, Training and Outcome
CPT Stephen T. Lifrak

Commodity Acceptance Studies in Pre-School Children of Developing Countries (Methodology Study in Beverage Acceptance by Children)
CPT Raymond C. Graeber

PACDA - Motivational Development Program - Role of the Personnel Management Specialty
MAJ Francis J. Fishburne, Jr.

Aviator Performance Measurement During Terrain Flight - Aircraft Control Movements Required During Low Level Flight With Rotary Wing
CPT Michael G. Sanders/ CPT Kent Kimball

Command Consultation - workshop on one way to do this in 10 easy steps - handouts provided
MAJ E. R. Worthington

What Do You Do When The Army Is Your Client? A discussion on professional identity within an Army-wide social action program
MS Marjorie Kaplan

Role Behaviors & Detection of Drug Use
CPT Larry H. Ingraham

How To Get Ahead In The Army and Is It Worth It?
COL Robert S. Nichols

Updating The Psychology Experience in Europe: A discussion of growth and problems in professional psychology in USAREUR
CPT John D. Shoberg

Function of the Psychologist in the Human Engineering Laboratories
Neil Johnson

MHCS - European Style
CPT Jack E. Bentham

OD - discussion
CPT William D. Siegfried, Jr.

Consultation With Physical Therapists: A Preliminary Report
CPT William J. Wisniewski

Psychological Aspects of Army Field Feeding - Paper and slide presentation
CPT Lawrence E. Symington

Military Police Performance as Related to Several Personality Variables and Educational Level
CPT Frank H. Rath, Jr.

Parent Effectiveness Training
CPT Harold D. Rosenheim

Impact of Army Plans (FY75-80) Upon Army Psychology
COL Robert S. Nichols

Desensitizing Non-Swimmers to Fear of Water
CPT Stephen T. Lifrak

Behavior Analysis and Change
CPT Stephen T. Lifrak

Clinical - Community Psychology
CPT James W. Futterer

Military Psychology
COL Robert S. Nichols

Experimental and Research Psychology
CPT Kent A. Kimball

Meeting for Organizational Psychology Consultants (or those interested in same)
MAJ E.R. Worthington

Internship Training Discussion
CPT Donald E. Pickleshimer, CPT Thomas K. Saunders

AD P003717

Proceedings of Current Trends in Army Medical Service Psychology
December 9 - 13, 1974, Fitzsimons Army Medical Center

THE HUMAN RELATIONS CENTER AT FORT POLK: PAST AND PRESENT (THE CHANGE PROCESS)

CPT James W. Futterer, Ph.D.
Chief, Psychology Service
5th General Hospital (Stuttgart)
APO New York 09154

INTRODUCTION

During the 1970s the U.S. Army has been forced to grapple with a number of issues and events which have led it to take a second look at how the needs of the individual soldier and his family are being met. At many installations behavioral scientists have been deeply involved in a variety of efforts to meet these needs. At Fort Polk, Louisiana, one attempt to meet these needs has been the creation of a centralized helping agency, the Human Relations Center.

Some of you have heard others describe the Human Relations Center at Fort Polk at previous conferences and have some familiarity with the principles upon which it was founded. Others may be familiar with programs at other installations such as Fort Lewis, Washington, or Fort Campbell, Kentucky, which have attempted to provide more efficient and effective services to the military community through cooperative efforts. Many of these programs have now been in existence for several years and have undergone numerous changes since their conception. Today I would like to address you about: (1) some of the changes I have seen in the Program at Fort Polk; (2) some of the factors involved in the initial and continued success or failure of such a program; and (3) some issues of importance in establishing and making such a program a viable one.

HISTORY AND DEVELOPMENT

Prior to the establishment of the Human Relations Center in January 1972, the Fort Polk community had available to it the traditional Army mental health facilities (MHCS, Inpatient Psychiatry, Hospital Social Work Service), social service agencies (Army Community Services, Army Emergency Relief, American Red Cross) as well as the newly established Drug and Alcohol Program resources.

Through the efforts of the Post Commanding General, the Deputy Installation Commander, the Hospital Commander, and the Chief of Psychiatry, these agencies were combined into the Human Relations Center

(HRC). It was felt that this unification of services would accomplish several things. First, a single center would serve to eliminate much of the duplication of services existing with separate agencies and allow for more efficient utilization of trained behavioral science personnel. Second, it became clear that to view drug and alcohol abuse as distinct problems separate from the social-emotional problems, instead of as an additional set of behavioral symptoms, was an error. Third, the combination of services would afford the person seeking help one location and one helping organization capable of handling multi-faceted problems. Finally, it would provide for the integration of views and understanding from both the line and medical perspective since individuals from both backgrounds would be working together in various sections.

Since its conception the Human Relations Center has been affected by both internal and external change. Changes within the Army, in the post organization, and of the post and hospital commanders have all had an effect upon the center as have changes of personnel within the center itself. A look at the Center as it was, and as it is, will hopefully provide some insight into the effect of these changes and their implications for the development and continued existence of such a center.

STRUCTURE & POSITION OF THE HUMAN RELATIONS CENTER - PAST AND PRESENT

When initially established the Human Relations Center enjoyed strong command support as a new and innovative program. This support was reflected in the Center's position within the post organization. HRC was seen as a command program responsible directly to the Deputy Installation Commander who reported directly to the Commanding General. This positioning had several advantages such as strong and immediate command support concerning community programs and treatment cases.

Since 1972 Fort Polk, like the Army itself, has undergone structural changes. The elimination of the Deputy Installation Commander position and a change in post commanders resulted in a shift of the Center's position within the post organization. The accompanying split of the Directorate of Personnel and Community Acitivites (DCA) brought with it the establishment of the Human Relations Division of the Director of Community Activities.

In this manner the Human Relations Center became the Human Relations Division. It no longer holds its high position within the post structure but is now grouped along with the Installation Club System, Recreation Services, the PX System and other activities as a division of DCA. This has resulted in a lengthening of the chain of command and a decrease in the Center's access to command. Where previously access to command went from the Director of the Center, to the Deputy Installation Commander, to the Commanding General, it now goes from the Director of the Center, to the DCA, to the Chief of Staff, to the Commanding General.

Along with the change in post position and the change of post and hospital commanders have come several internal changes in the organization of the Human Relations Division. Initially the various sections of the Human Relations Center were organized functionally into three broad areas of responsibility, namely: (1) social services, (2) education, and (3) treatment and rehabilitation.

Social services were located in the Combined Services Section. These services included: (1) the Army Emergency Relief; (2) the Consumer Protection Office which had direct liaison with the local Chamber of Commerce, as well as the Louisiana State Consumer Protection Office; (3) the American Red Cross; (4) referral services to other on and off post agencies; and (5) a representative from the Army Community Services.

The section responsible for education was the Education Committee which was also seen as the Community Consultation Team. This section was staffed with a number of lieutenants and an NCO, all who had prior line unit experience. The Education Committee conducted the community education covering both mental health and drug and alcohol abuse, as well as disseminating information on the services available at the Human Relations Center. Additionally, it developed and implemented all the community action programs established by the Human Relations Center.

The sections within HRC which were concerned with treatment and rehabilitation are best understood by focusing on the specific problem area primarily dealt with by each section. There were basically three broad areas: (1) drug rehabilitation; (2) alcohol rehabilitation; and (3) counseling and therapy for social-emotional problems.

The drug rehabilitation program was housed in the Polk House while the alcohol rehabilitation program was housed in the Halfway House. These two sections provided both resident and non-resident treatment for drug and alcohol related problems.

The sections of HRC that dealt with social-emotional problems fell within two broad categories: (1) inpatient or resident care; and (2) outpatient or non-resident care. The two inpatient sections were the Inpatient Psychiatric Ward and the Hospital Consultation Service (Social Work Service). All cases admitted to the hospital medical wards were the responsibility of the Hospital Consultation Service. This section also provided social work consultation to the Inpatient Psychiatric Ward.

The outpatient sections that provided assistance for social-emotional problems were of two types: (1) emergency; and (2) appointment. The Crisis Team was a 24-hour crisis service available for emergencies. This section provided one session crises intervention, and made referrals to the appropriate section in the Human Relations Center for further treatment.

Persons who sought help in other than emergency situations could obtain appointments at either Mental Hygiene Consultation Service or Family Consultation Service. Due to the nature of Fort Polk, as the Army Infantry Training Center, MHCS provided counseling and evaluation services primarily for persons involved in either Basic Combat Training (BCT) or Advanced Infantry Training (AIT).

Permanent Party personnel, retired personnel, and their dependents were seen at Family Consultation Service where they were provided with individual, marital, family, and group counseling and psychotherapy. Since Family Consultation Services was physically located with the social services, assistance for individual and family problems involving financial, legal, or consumer difficulties was immediately available at one location. This proximity was important in that the emphasis at Family Services was on providing assistance to the families of individuals with multiple problems related to drug or alcohol abuse.

Control of the Human Relations Center was exercised jointly by the Director, Human Relations Center (the post ADCO) and the Director, Professional Services (Chief, Department of Psychiatry). Overall administrative responsibility for the Center and direction of the Combined Services sections fell mainly to the Director, HRC, a line officer, while treatment programs and their implementation fell mainly to the Director, Professional Services, a Medical Corps officer. Joint control was necessary because of the inter mixing of personnel from both the line and hospital TDAs within the various sections, and the overlap in responsibilities regarding the drug and alcohol program and the Family Consultation Service. In actuality, the lines of responsibility were frequently merged/crossed, and a source of both conflict and strength for the Center.

The Human Relations Division as it now exists is divided into two main branches, the Drug and Alcohol Rehabilitation Branch, and the Army Community Services Branch. The Mental Health Social Services Branch is a function of MEDDAC which operates in close association with the Human Relations Division.

Under the new organization the Drug and Alcohol Branch includes the Polk House and Halfway House facilities and staff and also the Education Committee. These sections have retained their original functions.

The Army Community Services Branch consists of the Army Emergency Relief and Consumer Protection sections from the old Combined Services Branch and the traditional Army Community Services (ACS) in a more direct manner. Under the new organization ACS has become a part of the Human Relations Division with the Chief, Human Relations Division assuming the additional title of ACS officer. Family Consultation Service which was originally a part of the Combined Services Section has shifted to the Mental Health Social Services Branch and the Referral Services Section has ceased to exist as a separate service.

The Mental Health Social Service Branch includes Mental Hygiene Consultation Service, Family Consultation Service, the Inpatient Psychiatry Ward, Hospital Consultation Service (Social Work Service) and the Crisis Team. Family Services, which was originally developed as an adjunct to the drug and alcohol program, has now taken on the additional role of psychiatric outpatient clinic for the hospital. The Crisis Team provides 24-hour, one session crisis intervention for drug and alcohol emergencies as well as emergency evaluations for psychiatric problems.

Administratively and functionally the control of the Army Community Services Branch now clearly rests with the Chief, Human Relations Division while administrative and functional control of the Mental Health Services Branch clearly falls to the Director, Professional Services. The Drug and Alcohol Rehabilitation Branch is operated jointly by these individuals. The Chief, Human Relations Division has administrative responsibility for the total program while the Director, Professional Services has responsibility for providing treatment direction and support.

The original staffing of the Human Relations Center was accomplished by combining the staffs of: (1) the Drug and Alcohol Prevention and Control Programs; (2) the Department of Psychiatry, Mental Hygiene Consultation Service, and Hospital Social Work Services from the hospital; (3) the Army Emergency Relief; (4) the American Red Cross; and, (5) representatives from Army Community Services. Additional administrative personnel were also assigned to the Center by the Deputy Installation Commander from the list of excess line officers, and NCOs. This combination of resources provided approximately 25 officers, 29 enlisted personnel, and 21 civilian employees for a total staff of 75. Currently the three associated branches of the Human Relations Division derive their staffing from the same sources. Presently there are approximately 11 officers, 21 enlisted personnel, and 18 civilian employees for a total of 50. The 14 officer losses by branch were: 9 Infantry, 3 Medical Service Corps, 1 Medical Corps, and 1 Chaplain Corps. This breakdown of officer losses reflects not only the reduction in the size of the Army but also the decreased command emphasis for the Human Relations Division.

The changes in Command, in position within the post structure, in the internal structure, and the reduction in staffing have all affected the functioning of the Human Relations Division.

With the change in post commanders and the change in post position the Center lost not only its ready access to the commander but also the personnel and financial support which flowed from the post resources in abundance. The Center suffered a significant loss of status amongst the post organizations and found it much more difficult to implement programs and effect changes on the post. Even the level of cooperation regarding individual treatment cases seemed to decrease with the shift in command emphasis away from the Human Relations Center.

By the time the new post commander arrived the Center had lost its newness and, more importantly, was not a personal achievement from which the new post commander could derive the recognition which had befallen the previous post commander. This was also true of the new hospital commander. Thus, the Center slipped from the "favored son" position which it had enjoyed to the status of a specialized staff agency within the Directorate of Community Activities.

During the same period there was a shift in the relationship between the MEDDAC commander and the post commander with the creation of Health Services Command. This resulted in a more autonomous MEDDAC commander who became more protective of his resources and personnel. One result of this changed relationship is the clear distinction now found between the Mental Health Social Services Branch and the other branches of the Human Relations Division. This clear distinction coupled with the loss of line personnel has lessened the daily contact of the line and medical personnel within the Center.

Internally, the decrease in command support and the change in post position have taken a toll in all areas but particularly in those areas often referred to as "nice to have." The Referral Service no longer exists except within each section. Representatives of AG, JAG, and the MPs are no longer located within the Center and have not been for some time. The Consumer Protection Office which was previously staffed by a full time line officer and supported by the administrative secretarial pool is now a function of ACS volunteers who basically refer individuals to the state Consumer Protection Agency. Each of the major sections previously had a line officer assigned as an assistant to the director. These individuals provided a vehicle through which the line units and commanders could more effectively utilize and communicate with behavioral scientists.

The Education Committee which is charged with the vital task of carrying programs and information to the community has been reduced from a staff of 5 line officers and one NCO to one NCO. This individual by himself is barely able to continue the briefing program for incoming personnel and the educational commitments to the Fort Polk Academy much less develop and implement community programs.

Other internal changes have occurred which seem to be a function of time and the bureaucratic process. The structure within the Center has become much more formalized and areas of responsibility are more clearly defined. This certainly lends itself to a more orderly transition for new personnel and helps to maintain continuity in program direction. On the other hand, it tends to inhibit flexibility and makes it easier to avoid some of the more difficult tasks which do not clearly fall within the area of responsibility for any one section.

While what has been described up to this point does not convey an optimistic picture, it is somewhat misleading. All of the above

difficulties, and indeed many more, have beset the Human Relations Center and in many ways influenced its development. Not all of the influences have been negative, and in many respects the Center is now more effectively meeting the needs of the community than when it was first formed.

FACTORS INVOLVED IN THE CONTINUED EXISTENCE AND SUCCESS OF THE CENTER

The continued existence of the Center, in a time of program reductions and decreasing strength levels Army wide, suggests that it is of some value to the Fort Polk community. That it has also been seen as valuable by successive commanders is attributable to several major factors: (1) that the concept is a good one and in fact does help to meet the needs of a volunteer Army; (2) that the Directors of HRD and the Directors of Professional Services have seen the program as a viable program and have been committed to its continued existence; (3) that the staff of the Center, both line and medical has shown a high personal involvement; and, (4) that this commitment by the Center's personnel has resulted in programs which impact on the military mission of Fort Polk.

That the concept is a good concept is based not only on its face validity but also on results. Even with the lowered strength levels the Center is able to provide quick, comprehensive intervention for multiple problem situations. Personnel lose less time from duties due to the coordinated efforts, and units receive prompt feedback regarding their personnel as well as information useful to them in assisting members of their unit in difficulty. Individuals requiring special actions involving the coordination of several agencies often express surprise at the speed with which it is accomplished.

The commitment of the Chiefs of the Human Relations Division and the Directors of Professional Services to the concept of the Center has been essential to its continued existence and effectiveness. Because the Center is an unusual organization, (it does not conform to a standard TDA, utilizes personnel from various command sources, and has a duel chain of command) it has been frequently under question by various staff and command agencies. It has required a continuous and coordinated effort on the parts of the Chiefs of HRD and Directors of Professional Services to sell the concept to these agencies.

This ability to sell the program has to a great extent been due to the Center's involvement in programs which impact on the military mission of Fort Polk. It has been from this perspective rather than a humanitarian perspective that various commanders have seen the Center as a viable concept. Several programs which assessed the impact of various training procedures on new soldiers' ability to adjust to military life have proven useful to commanders as has a year long study of sources of Drill

instructor dissatisfaction. Some of the results of these assessments have been passed on to DA and have significantly influenced policy decisions at that level.

Currently a pilot program utilizing sensory integration technique with trainees who experience difficulty with marching, basic rifle marksmanship, and other activities requiring sensory-motor integration is underway. Initial results suggest that many trainees who are now being eliminated because of coordination difficulties may be salvaged with a 10 hour program of sensory integration training.

Activities of this type which in many cases are the result of line and medical staff working as a team are what have gained the Center Directors and Chiefs of Professional Services credibility and ready access to new commanders at all levels. In fact, recently there has been some concern on the part of the MEDDAC commander and the DCA as to which can forward recommendations and assessments to the post commander in the most expeditious manner.

MAJOR ISSUES

Based on the foregoing discussion, two issues seem to be pertinent at this point, namely: how does such a center get its start and then keep going, and who should direct such a program.

In regards to the first issue, most current programs of this nature have been established from above. That is, commanding generals have been interested in the area and have directed their establishment. At Fort Polk the Human Relations Center was created in three days after a meeting of the post commander, the Chief of Psychiatry, and the ADDCO which was initiated by the post commander. Not every post is going to be fortunate enough to have a commander who is interested in such a program on his own. Still, command interest and support is the way in which such centers get started and remain active. The problem, of course, is gaining access to the highest levels of command and then of selling the concept.

At Fort Polk initial command support was present from the start but as indicated above commanders have changed and so has the level of command support for the Center. In effect, it has been necessary to continually sell the program to new commanders. This is similar to the situation facing the person desiring to establish such a program. One major factor which has enabled the directors of the Center to sell the concept that has already been alluded to, is the involvement of the various sections in programs which impact on the military mission of the post. Programs which assist the commander in accomplishing his mission are what gain his interest. A short while ago reference was made to several programs at Polk and a closer look at them may be useful.

Several training policies which were implemented at Fort Polk had the effect of increasing MHCS referrals by as much as 60%. Since these policies were not implemented in all training companies it was possible to identify them as the source of increased referrals. Once this was researched and brought to the attention of the directors of the Center, a plan to evaluate the desired results of the policies was developed. The new post commander was then approached about the problem and presented with an alternative at the same time. A short research project was then implemented which showed that in fact the policies were having an effect which was opposite of what was intended. Several modifications were suggested which reduced the referral rate to MHCS and also enabled command to progress toward the desired goal.

Similarly, during the December 1973 to February 1974 period the personnel at Family Services noted a significant number of Drill Instructors were requesting release from Drill Instructor status and assistance with family problems. A check of past records indicated that in fact there was an 800% increase in Drill Instructor requests for assistance over the same period for the previous year. Again when he was informed the post commander was extremely interested. Family Services then initiated what has become a year long research project regarding sources of Drill Instructor dissatisfaction and difficulties. The information provided to the commander on a regular basis not only alerted him to the situation but also provided him with hard data which he then used in a message to Department of the Army. One of the difficulties that surfaced was the stress factor of personnel shortages and the resulting long work hours. A second factor which came to light was that 78% of the DIs seeking assistance had been on status for 3 or more years. Recently Department of the Army has implemented a policy of non-voluntary assignment to DI status and has also indicated that a tour as a DI will be necessary for promotion in some MOSs. Department of the Army has further indicated that the length of such tours will be limited to two years and only in exceptional cases extended to three years.

In both of these cases the agencies were concerned about the problems of their clients and the increased workloads for their decreased staffs. Frequently such concern has been dealt with by tirades against "the system" or "the Army" or with appeals to command to recognize how many people are unhappy with their situation. Usually neither approach has been successful. It was only when these problems were translated into the language of the line officer and their impact on his mission was made clear that action was taken to correct them. These activities have had an additional benefit in that personnel from the Center have now been included on a number of policy making councils at post level.

In another instance, the Child Guidance Unit recognized that there were significant numbers of children in the Fort Polk community with perceptual-motor difficulties and that there were no local facilities for treatment in either the civilian or military community. Attempts were made to

obtain additional personnel to initiate a program of this nature, but little came of these attempts until the situation was translated into military terms. Again a request was made for additional resources but this time the request was made on the basis that such a unit would significantly reduce the number of compassionate reassignments for families with such difficulties. It was pointed out that such a program would more than pay for itself from the savings in moving expenses incurred with the compassionate reassignments. This approach resulted in the establishment of the sensory integration program and the acquisition of three additional civilian slots to staff it.

An offshoot of this program has further served to strengthen command support for the Human Relations Division. It was noted that many of the trainees who were being discharged for ineptitude and failure to adapt to the military had problems that were similar to those of the children with sensory integration difficulties. Several company commanders who had individuals scheduled for discharge were encouraged to try some of the techniques utilized with the children. They worked so well that a program is now being developed for post-wide usage at the request of command.

These types of activities are what has sold the Human Relations Division concept to new commanders at Fort Polk. Many other activities such as these are necessary if the concept of a comprehensive helping center is to remain a viable one.

Of equal importance with the development of activities which meet not only individual needs but also military needs are the individuals who hold the Directorship over the Center. This, of course, is the essence of the second major issue.

One of the unique features of the Human Relations Division at Fort Polk is its dual chain of command. The Director of the Division is on an equal level with the Director of Professional Services. This dual directorship if it is to work requires an extremely close working relationship between these individuals. Each of their roles and needs must be understood by the other as well as the demands placed on each by their separate commands. In a sense a balance of power must exist in which each is able to realize that by working together they actually control more resources and can exert more influence than either one would working independently. Many of the efforts of the Center referred to above were possible only because there was a trust relationship between the two directors. Each was able to realize that the other brought a different perspective, different resources, and different skills to bear on each situation which when taken together produced more viable progress and activities than either could alone.

This dual directorship has the effect of allowing both the post and hospital commander to perceive the Division as his program while

recognizing the involvement of the other. It provides each commander with a contact point with whom he can relate comfortably and identify. This also allows for two entry points into the chain of command rather than the usual one.

The major difficulties with the dual directorship are that it is in many ways dependent upon the personalities of the individuals filling the two positions, and it can produce a split in allegiance amongst subordinate personnel. Yet these difficulties have been overcome more easily than might be expected. Experience has shown that individuals filling these positions have quickly come to realize that they need each other's cooperation if the Division is to continue.

The position of Director of Professional Services is the position most related to our functioning as psychologists so a closer look at it seems in order. At Fort Polk this position is filled by the Chief of Psychiatry but is this necessarily so. A look at the qualifications necessary or helpful for functioning in that position may prove insightful.

The individual who fills this position must possess a knowledge of and philosophical orientation toward community mental health, he should be of field grade rank, have ready access to the hospital commander, and possess the ability to function in, and enjoy functioning in, "political realms" both within MEDDAC and at the post level.

Traditionally the Chief of Psychiatry is viewed as possessing these qualities by virtue of his medical degree. Obviously the psychiatrist has no corner on knowledge or skills in the community mental health area for psychologists and social workers also have expertise in this area. Similarly, interest, philosophical orientation, and enjoyment of political operations are not restricted by profession. Yet many people not directly involved in the mental health area perceive the psychiatrist as the only person who possesses this knowledge and ability. The medical degree, in essence, provides him with instant credibility both with his medical colleagues and non-medical personnel.

Because in the military much of an individual's credibility is based upon his rank, it is essential that the Director of Professional Services be of field grade rank. This is also important to maintain a balance of rank with the line officer who holds the position of Director of the Center or Division. By virtue of his medical degree the Chief of Psychiatry typically holds field grade rank. This has not been the case with either psychologists or social workers as we are painfully aware.

Access to the hospital commander is also more readily available to the Chief of Psychiatry by virtue of his medical degree. While the Chief of Social Work holds an equal position as a Department Chief, his access to and acceptance by the hospital commander is often limited by his MSC brass, for MSCs are perceived as responsibility of the executive officer.

Psychologists not only wear MSC brass but are also organizationally a Service under the Department of Psychiatry, and commanders typically deal with Department heads.

These factors at first suggest that the Chief of Psychiatry is the logical choice as Director of Professional Services. Still several other factors suggest that perhaps he may not be the most logical choice. In the future, hospital commanders may be very reluctant to "lose" a physician to this type of position when they are in short supply. There is the possibility that in the near future there may not be sufficient psychiatrists in the Army to provide coverage for even the more traditional activities.

On another level the psychiatrist may not be the most logical choice. Because of his newness to the Army, despite his field grade rank, he is often not aware of many of the factors operating about him. Psychologists and social workers are now beginning to remain in the military beyond their obligation and many are approaching consideration for promotion to field grade rank. Individuals who have prior military service have been recruited as military psychologists and now hold field grade rank. These individuals bring with them a familiarity and commitment to the military that is missing in most of the Medical Corps officers, but very helpful to the director of a comprehensive program.

During this presentation many issues have been touched upon, hopefully some have been clarified, others still need exploration and discussion. Many opportunities exist for behavioral scientists of all professions in the Army. The formation of a coordinated helping agency is only one, but I feel it is a good one.

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Commodity Acceptance Studies in Pre-School Children of Developing Countries

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In July 1971, eleven DOD research laboratories throughout the country joined together to form the DOD Technology Transfer (T^2) Consortium. The purpose of this group is to further the transfer of existing knowledge, facilities or capabilities, acquired while working on military R&D projects, to the solution of local and national civilian problems. With the encouragement of both the Undersecretary for R&D and the National Science Foundation, this group has since grown to 28 member laboratories providing scientific and technological assistance to civilian probelms in law enforcement, highway safety, pollution control, and other areas.

It was with the aims of the T^2 Program in mind that our laboratories responded to a request by USDA and the Agency for International Development through the Secretary of the Army for our assistance. Secretary Butz pointed out that the Food for Peace Program was faced with an extremely short supply of non-fat dry milk powder and that a USDA-AID group had a requirement to identify a new, equally nutritious, beverage product for use by pre-school children by 1 Jan 74. He requested assistance from the U.S. Army Natick Laboratories (NLABS) to develop and test a methodology for determining the acceptability of this product to intended recipients and to monitor its use in field tests carried out by USDA.

The Department of the Army advanced this requirement to NLABS, an interagency agreement was reached, and funds were transferred to NLABS on 16 July 1973. The work was carried out by an NLABS team of psychologists from the Pioneering Research Laboratory working with two psychological consultants engaged by USDA. Over a four month period, acceptability criteria and acceptance methodology were developed and tested at the NLABS and in the Dominican Republic, and field tests were conducted in the Dominican Republic by the NLABS team and in five other countries (Chile, India, Vietnam, Pakistan, and Sierra Leone) by the USDA consultants. These countries were selected by AID as representative of the major cultural and geographical regions to which title II commodities are distributed.

Scientists at USDA's Dairy Products Laboratory had done considerable basic research in previous years on a milk-like beverage mix composed mainly of soy products and cheese whey, a serious pollutant in U.S. streams and

rivers. As formulated, this whey-soy beverage powder contained 20% protein, 20% fat, and high levels of vitamins and minerals, and when reconstituted (15% solids by weight) was nutritionally equivalent to whole milk. The USDA contract called for a 30 November 1973 decision by NLABS as to whether this powder was acceptable or not in each of the six representative test countries, and if not, what changes would be required to make the product acceptable.

Relatively little acceptability testing had ever been done previously with new foods being introduced into the Food for Peace program. The little amount that had been done consisted of anecdotal evidence, "expert" opinion, and general impressions gathered from trial distributions at selected sites in a few countries. Not only did this non-scientific approach lead to occasional serious and expensive misjudgements about a product's acceptability but it also required a couple or more years to carry out.

The aim of this project was to develop within a relatively short timespan a sensitive, simple, yet scientifically reliable, method for assessing product acceptability in a variety of cultural settings and age groups. With this in mind, the NLABS-USDA team spent the month of August in the Dominican Republic testing out various suggested techniques using both sweet and bitter flavored non-fat dry milk. After testing over 900 children and 160 mothers, a final method was devised which measured consumption of up to three possible 8 ounce servings per person, both children and adults, and included a five minute questionnaire for mothers and staff.

During the actual field testing begun in September, data was gathered on several indicators of acceptability and on various product characteristics such as taste, texture, odor and similarity to other foods common to the locality. However, only two major criteria were used to make the final decision on the acceptability of the whey-soy beverage for each country:

1. % children, 6 years or younger, who consummed at least 8 oz, and

2. % mothers who responded that they liked the product on a five-point hedonic scale.

Testing was conducted in a variety of distribution systems within the different countries. In many instances the whey-soy beverage was evaluated in maternal-child health centers or orphanages where preschool children came daily for a prepared meal. Other test centers required setting up a situation to measure intake since normally the milk powder was reconstituted at the center and taken home for consumption. A similar problem was encountered at so-called dry distribution centers, usually a medical clinic where mothers brought their children for monthly checkups and were then given a month's supply of beverage powder for each malnourished preschool child. As Table 1 shows, tests were often conducted both at the beginning and end of several days or weeks experience with

the product. This not only permitted assessment of any changes in acceptability due to repeated exposure to the whey-soy beverage but it also allowed us to gather detailed information about home preparation, additives, illness, etc.

In order to make a decision as to the acceptability of the beverage from the data collected, it was necessary to establish certain standards for each country. This was done by questioning the local representatives of the volunteer agencies (CARE, Catholic Relief Service, Church World Service) who actually order and distribute the Food-for-Peace commodities overseas. Assuming recent introduction of a new hypothetical beverage commodity, they were asked to state the maximum percentages they would tolerate of children not consuming 8 ounces (i.e., criterion 1) and mothers disliking the product (i.e., criterion 2).

Overall, more than 4,000 children and 2,000 staff and mothers were tested. The results indicated that the whey-soy beverage powder should be acceptable in all test countries except Sierra Leone. The next Table (Table 2) shows the summary of the results for one of the countries, Chile, and compares them with the respective levels of acceptance stated by the volunteer agency representatives. Note that some tests were also carried out with sugar added since this sweetener was typically added at homes and centers in this country. At all times we attempted to mimic as closely as possible the actual eventual use of the product. However, this was not possilbe in Sierra Leone since its people typically served such beverage powder commodities as a "pap" to children, whereas USDA and AID insisted that testing be conducted on the product only as a beverage. This discrepancy between normal usage and testing probably accounts for the low levels of acceptance as seen in the next table (Table 3).

On the basis of our acceptability report as well as other considerations, the Commodity Credit Corporation approved whey-soy beverage powder for large scale production and world-wide distribution in December 1973. Current orders by foreign governments indicate a projected shipment of 10 million pounds within the first year leading to an eventual yearly distribution of 120 million pounds by Food for Peace.

This project, besides providing direct information on the acceptability of the whey-soy beverage powder, has made significant strides in developing a scientific basis for making costly decisions on the distribution of food commodities in a world becoming increasingly in need of such large scale feeding programs. We are pleased to have had the opportunity to be of assistance to the USDA in this important national program and believe that this is an unusually good example of the implementation of the new policy of the Executive Branch on expanded cooperation in the use of federal laboratories for national requirements when information is needed to guide the technical content of policy decisions relating to an urgent civilian need.

Table 1. Overall Testing Plan

Distribution	Product Experience	Day 1	No. Days Experience	Final Day
Wet	One-day Long Term	Test Test	6-9	Test
Dry	One-day Long Term	Test Test	18-63	Test

Table 2. Summary of Child Intake and Mother Acceptance Data for Chile

Data Type	Product Tested	Site-type	Whey-Soy Wet		Whey-Soy + Sugar Wet		Voluntary Agency Representatives' Criterion
Intake	Children consuming at least 8 oz.	One-day	19%	(124)*	61%	(115)	
		Long Term Initial	17%	(126)	68%	(112)	66%
		Retest	89%	(112)	95%	(64)	
Questionnaire	Mothers liking product	One-day	75%	(26)	88%	(33)	
		Long Term Initial	32%	(17)	100%	(15)	64%
		Retest	-	(0)	-	(0)	

*( ) = Number of subjects

Table 3 Summary of Child Intake and Mother Acceptance Data for Sierra Leone

Data Type	Product Tested / Site-type		Whey-Soy Wet		Whey-Soy Dry		Voluntary Agency Representatives' Criterion
Intake	Children consuming at least 8 oz.	One-day	58%	(132)	41%	(140)	
		Long Term Initial	-	(0)	13%	(83)	55%
		Long Term Retest	-	(0)	44%	(140)	
Question-naire	Mothers liking product	One-day	89%	(9)	86%	(28)	
		Long Term Initial	-	(0)	100%	(20)	45%
		Long Term Retest	-	(0)	92%	(59)	

*( ) = Number of subjects

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PREDICTORS OF PILOT-ERROR ACCIDENTS

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Michael G. Sanders (CPT, MSC) presented a paper entitled "Predictors of Pilot-Error Accidents" based on a previous publication (Sanders and Hofmann, 1975).

SUMMARY

Pilot-error accidents have dominated accident statistics consistently from the 1940s to the present. Sanders and Hofmann (1975) found that three factors from Cattell's Sixteen Personality Factor Questionnaire (16 PF) showed significant differences ($p < .05$) between pilot-error accident groups and were used to correctly classify 86% of the aviators tested as to their previous pilot-error accident involvement. Sixty-six aviators were given the 16 PF in the present study in an attempt to cross-validate the findings reported in the original study. The results indicate that the personality factors did not significantly discriminate between the pilot-error accident groups. The primary personality differences between the present sample and the original sample were due to variations in the pilot-error accident free groups. The findings indicate that individual differences in personality characteristics of the aviators prevent consistent identification of traits associated with pilot-error groups.

Sanders, M.G. and Hofmann, M.A. A cross-validation study of the personality aspects of involvement in pilot-error accidents. USAARL-USAAAVS Joint Report, March 1975. (USAARL Report No. 75-15 and USAAAVS Report No. 75-3).

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ADCO COUNSELORS

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Official ADCO policy states that a counselor's primary function is to act as staff advisor to company and battalion commanders to better enable them to rehabilitate drug and alcohol abusers in their units. This broad platform or policy indicates that the counselor's primary client is not the client he treats but rather the company or battalion commander; or, more broadly speaking, the Department of Army by whom he is employed for the purpose of eliminating substance abuses which tend to impair on-the-job performance of men in the unit. A major emphasis of the policy is thus upon the job situation and the relationship of the soldier to it.

The rationale for this policy is that the primary goal of the Department of Army is defense of the country. Defense of the country requires an adequate standard of job performance by all military personnel which, in turn, requires adequate health habits to sustain that performance. Drug and alcohol abuse* are ordinarily inadequate health habits which do not sustain performance but rather impair it. The ADCO programs are designed to address themselves to just such inadequate habits; but without the full cooperative support of company and battalion commanders, such programs must fail, since in the last analysis it is the commanders who have the final word on who will or will not be permitted or encouraged to participate in them. Although DA Cir 600-85 makes it plain that commander compliance in program participation is mandatory, and, in theory, this mandate could be enforced, practically speaking the mandate is best served by convincing commanders that program participation is in their own and the Army's best interests.

Gaining commander support is thus an essential task of the counselor; and in attempting to gain it he must first undertake to establish effective relationships between himself and the commander; between the commander and the unit; and

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*Defined on page 30.

between the unit and the ADCO generally.* Without an effective relationship between himself and the commander, commander referrals may decline. Without an effective commander-unit relationship, drug and alcohol abuse may increase. And, finally, without an effective ADCO-unit relationship, the ADCO may be less sensitive to those conditions within the unit that tend to reinforce drug and alcohol abuse. Thus, in these given respects, it may be validly seen that the commander is the counselor's primary client and that the chief weight of the counselor's efforts must be focused upon the relationship between the soldier and his job situation.

The essential ingredient in gaining commander support is visibility on the part of the counselor. He must be visible in both an educational and a rehabilitative sense. Typically, educational measures with troops are based on the hypothesis that probability of drug and alcohol abuse is reduced in any individual whose knowledge and attitudes towards drugs and alcohol have been shaped by realistic information and experiences. On this basis are built the many wide-spread educational efforts presently mounted within the ADCO and directed outward toward the military and civilian communities at large. These are preventive measures in the sense that certain individuals may never start to use drugs or alcohol in the first place as a result of having been adequately educated. They are rehabilitative in the sense that persons who have already begun to use drugs or alcohol may, as a function of adequate education, reduce or eliminate the use.

Personnel for whom such educational efforts are thought to be relevant include non-abusers (presumably commanders, DESs and 1SGs) as well as abusers, since misconceptions about drug and alcohol abuse and abusers are considered to be just as prevalent and just as potentially harmful in the one group as the other. The hypothesis held here is that the sort of information and attitudes that non-abusers have at their disposal may spell the difference between a therapeutic and

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*Obviously the extent to which a counselor can or should effect changes in these relationships is limited---first by circumstances outside of his control (the counselor actually represents a very small input to the unit picture overall); second by virtue of the fact that he is duty bound to adhere to a policy of fitting the man to the job vs "reforming" or "revolutionizing" the Army.

non-therapeutic milieu for persons subject to drug and alcohol abuse. In fact, it is considered that existence of valid information and attitudes alone may very well produce a genuinely therapeutic milieu, one in which the need to abuse drugs is significantly reduced.

In addition to educational and rehabilitative visibility as regards commanders and units generally, the counselor must also be involved in more direct rehabilitation measures. These more direct measures produce the evidence necessary to convince commanders that drug and alcohol abuse can, indeed, be eliminated or reduced in given individuals in the unit. It is primarily through use of sound counseling techniques that the counselor hopes to attain such proofs of "cure" or potential "cure."*

From the military point of view, these more direct rehabilitation measures represent an essentially secondary function on the part of the counselor in support of the primary goal of acting as advisor to the commander who will, himself, constitute the major rehabilitative effort for his men by maintaining a therapeutic unit milieu. It is of interest to contrast this military posture with its emphasis upon prevention (education), and commander-as-client, and improvement of relationship of individual to job situation, with that most prevalent in the civilian setting.

In the civilian setting the primary goal is the rehabilitation of already-deteriorated individuals with a major emphasis upon improvement of the relationship between the individual and himself and, to some extent, between the individual and others. The client in this setting is almost always the person treated regardless of who may be requiring and/or paying for the treatment (e.g., parent, spouse, employer, etc.). As regards preventive measures (particularly as in mass educational efforts), these have typically been of the least possible importance to the function of counselors in a civilian setting.

A further contrast, though by no means an absolute one, relates to the type of client seen in the military vs civilian setting. As a rule, the civilian client is more often a

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*"Cure" is, of course, a relative term. A final or ultimate cure in the sense of a client eliminating all drug abuse for the rest of his natural lifetime is beyond the scope of the ADCO program.

self-referral; or if not a self-referral, a person whose job performance (or lack of it) does not constitute a pressure upon the counselor to find a way to improve. In the military setting the client is more often an "other" referral. Typically, he is sent in to the ADCO by a commander because of impaired performance associated with drugs or alcohol abuse or because his urine proved to be positive on a biochemical screening test. Generally, the significant differences between self- and other-referrals are: (a) the self-referral may or may not be impaired in job performance; and, the impairment, if any, is no more a major presenting symptom than any other impairment, such as in the handling of personal/interpersonal relationships; (b) the other-referral is seldom a voluntary (cooperative) client.*

The possible polarization inherent in the two quite different goals and referrals of civilian and military life could pose a very real problem for counselors employed in a military setting. Most counselors are trained to regard the treated client as the only actual client and to regard the primary goal of treatment as the improvement of the relationship of the client with himself and others, regardless of what his job performance may be or if, indeed, there is a job in which the client performs at all. The counselor is not only trained to so regard the client and the goal as a matter of professional expertise, but, more specifically, as a matter of ethical professional expertise. For example, client welfare, in terms of self-self relationship, is usually held above all other considerations by the ethical counselor, to the extent that any potential danger to that relationship, as by breech of confidentiality or misuse of client for personal or outside gain, is guarded against assiduously. In fact, counselors licensed to practice (e.g., certain psychologists) may be legally barred from further practice if found guilty of such breech or misuse of a client.

Furthermore, even if the counselor wished to disregard his previous training and its major emphasis upon self-self and self-other relationships (in favor of self-situation relationship) the problem arises as to how the counselor

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*The various disparities indicated between civilian and military counseling situations are actually not as clear as here drawn. Recent trends indicate greater similarity on both philosophical position and implementation: e.g., as regards identification of the client, emphasis on the situation, emphasis on community education, type of referral, etc.

might handle this shift of emphasis for the increasing number of self-referrals lately showing up for treatment at ADCO centers. If the self-referral has no problem with impaired job performance, in spite of his problem with drugs and/or alcohol, the question arises as to whether or not the ADCO counselor should refer the individual in question elsewhere (e.g., to Mental Hygiene) or retain him for treatment at his own center.

The resolution of the apparent polarizations described above---such that a counselor may accept the Department of Army's goals and implementations without sacrificing the ethical-professional requirement that his first and foremost allegiance be to the client actually treated---is not as difficult as it may seem. First, it must be realized that civilian goals and implementations tend to support military ones; e.g., if a client is successfully treated, such that self-self and self-other relationships are improved, the tendency to abuse drugs and/or alcohol will in all likelihood be reduced and job performance improved accordingly.

Nonetheless, counselors in a military program cannot rest on this one point of resolution alone. Without altering the civilian posture as far as it goes, counselors must fully expand and incorporate the self-situation emphasis of the military scene into the counseling picture. In operational terms, this means that the counselor:

a. Accepts as his own value the value officially upheld by the Department of Army regarding drugs and alcohol, such that he attempts in every way possible to eliminate drug and alcohol abuse on the part of personnel in the Fort Carson community. Putting this concept in psychological terms, the counselor "owns the problem" of drug and alcohol abuse.*

b. Attempts by educational means to deliver comprehensive and valid information to the Fort Carson community (under the

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*"Problem ownership," further discussed in Section II, refers to the notion that he who feels discomfort re a problem is the owner of that problem. In the case of drug/alcohol abuse, the counselor may or may not feel any personal discomfort about problems of abuse but he definitely does at least agree to "feel" such discomfort officially as a function of his employment in the ADCO. In a manner of speaking, the counselor may thus be said to own the problem of drug/alcohol abuse by proxy from the Department of the Army.

auspices of ADEC) on the subject of drug and alcohol use and abuse.

c. Attempts through structured, systematic, and supportive personal contact with battalion and company commanders to create an atmosphere or climate within the unit which will tend to maximize fitting the soldier to his environment and, to some extent, the environment to the soldier (self-situation relationship).

d. Attempts through use of effective counseling techniques to improve the relationship of the drug- and/or alcohol-abuser with himself and others (self-self and self-other relationships).

e. Accepts the proposition that self-referrals, like other referrals, are valid clients for his own center so long as the presenting problem is related to drug and/or alcohol abuse. This proposition is held to be valid on the basis that whereas the self-referral may not as yet be impaired in job performance, he will in all probability be so impaired in relatively short order if left untreated.

f. Accepts the proposition that "abuse" means:

(1) Use of any drug that is illegal, regardless of amount or frequency.

(2) "Excessive" use of any drug, legal or illegal, with "excessive" defined by the clinical judgement of the counselor based upon a pattern of information elicited from the client, from the client's commander, from medical records and/or from other relevant sources.

It should be noted that even though Section I deals primarily with problems of abuse among active duty soldiers, Cir 600-85 provides that educational and rehabilitative measures also be afforded to civil service employees, retirees, and dependents of active service personnel. The general argument and development of Section I may be taken as reasonably parallel in the case of civil service employees ("commanders" may be read as "supervisors" in this case) since the emphasis is again on improving impaired job performance. Positions in regard to retirees and dependents, however, are not as decidedly parallel.

The rationale for inclusion of dependents and retirees in education and treatment is based in large part on a view of drug and alcohol abuse as being a kind of "communicable

disease." This view states that when an individual finds himself almost the only "hold-out" in a primarily drug-abusing group (as may very well happen when the drug in question is, for instance, marijuana) peer pressure to conform plus normal need for acceptance and companionship make it exceedingly difficult to resist the "infection" of drug abuse. Thus the social context (behavioral norms) is a fairly important variable in whether or not an individual will abuse drugs/ alcohol. Dependents are perhaps just as susceptible (or more so) to such "infection" as active duty personnel. Dependents who succumb to this "disease" may then themselves, as may active duty personnel, help spread the "disease." From being victims of the problem, they might now be said to have become the problem itself. The ADCO policy of education and treatment may thus be seen, when extended to dependents, as a kind of preventive public health measure.

It is also probably true that drugs and/or alcohol-abusing dependents may bring about a certain amount of job-performance impairment indirectly. This may occur as a function of the worry and stress that is frequently created in the abuser's family, particularly in the head of the household who may very well earn his living at Fort Carson either as a soldier or as a civilian.

Finally, as regards retirees, the general rationale is primarily that retirees, having served their country, are to be served in turn by their country for whatever ills may beset them. Although this posture has little or nothing to do with job performance improvement, it is very much in keeping with the generally humanitarian stance which the Department of the Army assumes as its obligation to retirees.

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HOW TO GET AHEAD IN THE ARMY
AND
IS IT WORTH IT

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I. WHAT CONSTITUTES GETTING AHEAD IN THE ARMY

- A. Increased rank
- B. Acquiring professional credentials (ABPP, "A" prefix, state licensure, etc.)
- C. Acquiring professional reputation, in and out of Army
- D. Getting better jobs
- E. Assuming greater responsibility, either technical or management or both

II. METHODS OF GETTING AHEAD

- A. CARDINAL RULE: Be competent and work hard.
- B. Be flexible. Do what needs doing, even if it means playing new roles and acquiring new skills. Fit yourself to the job, rather than the job to you.
- C. GROW - in both skills and breadth of viewpoint.
- D. Seek out responsibility and show initiative.
- E. Think broadly, both within psychology and in the wider context of the Army.
- F. Be a specialist in a few areas that are relevant to Army needs, but don't limit yourself to these specialties. Be prepared for, and comfortable in, a generalist role.
- G. Support the Army mission. You exist to support the Army. The Army does not exist to support you.
- H. Accept comfortably and fully your role as an officer. This implies accepting some administrative responsibility. Don't demand a narrow professional role totally devoid of administrative and supervisory obligations.
- I. Accept your responsibilities as a trainer, educator, supervisor, and manager. Learn to work with and through others.
- J. Don't offend people needlessly by insisting on professional status and prerogatives. If you are helpful to the Army, you'll get professional recognition. If you're not helpful to the Army, you won't get professional recognition no matter how much you demand it.
- K. Get all the military education you can (AHS, CGSC, War College, specialty courses).
  1. It gives you a broader feeling for the overall mission and scope of the Army
  2. It broadens your perspective and your awareness of new areas where psychology can be helpful
  3. It gives you useful contacts with other officers
  4. It increases your overall skills

L. Get all the civilian education you can
M. Maintain contact with civilian psychology, in state associations, schools, conferences, etc.

III. HERE ARE SOME THINGS YOU SHOULD NOT DO

A. Stay at one post too long
B. Expect the Army to fit your exact needs and preferences
C. Be a prima donna
D. Push the "Ph.D.," Pro pay," "professional" roles too hard
E. Offend your fellow MSC's
F. Limit your role and your contacts to the AMEDD - you are here to serve all the Army; don't stick to medical activities only
G. Do not expect a coherent, long-range Army psychology program. We simply cannot maintain enough career personnel to build long-range Army-wide programs. However, we can offer some very interesting jobs and careers to individual psychologists
H. Don't ignore your personnel records. If you don't check on their accuracy and completeness, no one else may do it. Be especially careful about efficiency reports, for both duty assignments and times when you are at school.

IV. WHAT ARE THE REWARDS

A. Some very interesting, challenging, and often novel psychological assignments
B. A change for considerable diversity of assignment, both in terms of the location of the jobs and their nature
C. Excellent educational opportunities
D. Very great professional autonomy
E. Increasing status
F. Reasonable pay. You probably earn less than you civilian colleagues in the early years, but catch up later in your career
G. Excellent retirement, at a relatively young age (@43 to 52) with a good income and with skills and experience that make it easy to get into a second civilian career
H. Some excellent fringe benefits (travel, including space-available aircraft travel, medical care, widow's pension, etc.)
I. Considerable time off, both in leave and TDY status
J. Job security, and a chance to try new professional roles

V. DISADVANTAGES

A. Frequent movement
B. Some handicap for children, especially as they reach late high school and college age
C. Some role ambiguity
D. Some unpopularity - civilian psychologists are sometimes critical of military ones
E. Potential problems if your wife has her own career goals and interests which conflict with your need to remain mobile
F. Bureaucratic inertia and rigidity

VI. CONCLUSION

A. Each of you has his own interests and needs, and each of you has his own way of proceeding. There are many routes of advancement and no single one is best, but I have tried to suggest the things that are more likely to succeed.

B. I've enjoyed my career, and learned a lot. It's not the right thing for everyone to do, but I hope some of you will choose it, and enjoy it as much as I have.

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UPDATING THE EUROPEAN EXPERIENCE IN PROFESSIONAL PSYCHOLOGY

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SUMMARY

This presentation traced the course of the development of the role of professional psychology in the European Theater from Fall 1971 to date. In August 1971 there were exactly three uniformed Army psychologists serving in MOS 3620 in all of Europe and no civilians. The advent of the Army's "war on drug and alcohol abuse" led to rapid increases in available personnel, particularly in the Department of the Army Civilian (DAC) sector. Authorizations for uniformed psychologists increased slowly at first. With the addition of five medical liaison offer slots for psychologists in 1974, total authorized personnel requisitioning authority (PRA) for fifteen MOS 3620 psychologists exists today. While approximately 10 military psychologists are present in November 1974, not enough professional personnel have been supplied to meet the need for a full compliment of fifteen. A sixteenth slot in the Office of Drug and Alcohol Abuse Control (ODAAC) in Heidelberg was filled by a social worker when a psychologist could not be provided. While the above suggests an atmosphere of missed opportunity, the actual picture is much brighter than it might be due to the dedicated professionalism and hard work by those approximately ten DAC and ten Army psychologists currently present in the theater.

Over the past three years a large number of psychologists have devoted most, if not all, of their time to drug and alcohol abuse programs throughout Europe. In 1972, control of most of the resources devoted to outpatient services for alcoholics and drug abusers was taken over by the line command as the problems of alcohol and drug abuse were then apparently conceptualized as primarily command rather than medical problems. This led to the appearance of a proliferation of "parallel" administrative structures in the form of both mental health (more or less under medical command) and drug and alcohol (under line command) programs; both fulfilling to differing degrees, Army administrative and professional needs in areas with obvious community health implications. One major problem that remains is that of how to best organize these resources to provide the most comprehensive and efficient services; for example, to an alcoholic with moderate to severe family problems. Such a problem appears, in practice, to require expert consultation

if not intervention by professionals with skills usually beyond those of even the most dedicated 91G behavioral science specialist alcohol counselor. A commonly heard comment is that professional supervisory personnel available to such counselors are so burdened with administrative details and the large number of alcohol counselors they are responsible for such that professional supervision is not sufficiently available to meet even reasonable demands for it. In order to facilitate the delivery of more comprehensive and direct services to all personnel in the theater, a mental hygiene regulation has been proposed for USAREUR and Seventh Army. This regulation would result in placement of professional behavioral science personnel as chiefs of mental hygiene consultation services in the major and many smaller communities in the European command. Presently, the most comprehensive services are available in or nearest to large hospital centers. Under the proposed regulation, professional personnel should be more dispersed. It has been suggested that one professional person might even serve as chief for more than one community with his supporting behavioral science specialists actually living in each of the communities receiving on-the-scene support. Hopefully, drug and alcohol abuse counselors and their clinics can be more fully integrated into the mental hygiene picture in the future in order to provide full balance and scope to both our preventive and treatment functions as members of the mental health and helping professions. The need for continued command interest and support for mental hygiene and drug and alcohol abuse efforts is fully appreciated, recognized, and encouraged. It is hoped that the proposed mental hygiene regulation will assist in providing more comprehensive direct services in a high percentage of communities in centers more conveniently dispersed throughout the command.

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A COMMUNITY BASED HUMAN RESOURCE CENTER: A EUROPEAN PREREQUISITE

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"Some men look at the way things are and say why. I dream things that never were and say why not."

Robert F. Kennedy (1968)

INTRODUCTION

Julian Huxley's (1959) statement "human life could gradually be transformed from a competitive struggle against blind fate into a great collective enterprise, consciously undertaken...for greater fulfillment through the better realization of human potentialities" (p. 409) has taken on new meaning with the advent of preventative mental health movements. The community mental health or human resource center serves a vital liaison between the often ill-defined path between individual helplessness and eventual hospitalization. Located within the community confines, it can more readily spread its tentacles and foster healthy physiological, intrapsychic, phenomenological and sociological adaptation of community members. Emphasizing an early diagnosis-better prognosis philosophy, prompt treatment of maladaptive behavior is afforded. The military community meets all White's (1959) prerequisites for community functioning. Within CONUS the human resource center philosophy has been successfully implemented. Outreach programs concentrating on implementation of sound psychological principles have been skillfully intermixed with in-house individual, marital, family, and group counseling to provide a vibrant concoction designed to develop more effective coping behavior. The purpose of this paper is to summarize the characteristics of European communities, to emphasize stresses placed on community members in USAREUR and discuss implementation of the human resource center concept.

CHARACTERISTICS OF THE EUROPEAN COMMUNITY

The European community is divided into sectors with a hospital and outlying MEDDAC dispensaries responsible for the entire medical treatment of American citizens regardless of the government connection. Judiciously, the individual soldier is responsible to the Uniform Code of Military Justice (U.C.M.J.). However, his dependent counterpart is under German jurisdiction.

Outlying medical, dental, and veterinary facilities are located in detachment areas serving a population from 500 to 5,000 individuals. Each of these communities have housing facilities with distribution determined by rank, time-in-command, military sponsorship and family size. Each family when assigned to government quarters occupies a stairwell along with five additional families. Playground facilities are provided servicing on an average of a four-stairwell-per-playground basis. Each stairwell occupant is responsible to the ranking stairwell serviceman who acts in the capacity of a stairwell coordinator and is responsible to the community commander. Each serviceman who occupies a stairwell forfeits his housing allowance and in replacement receives his shelter with utilities and government furnishings provided. Approximately 95% of the "European" dwellers decide to accept government quarters sometime during their European tour. For those who remain in economy quarters a station housing allowance (determined by a formula including the mean rental cost in each area), cost of living allowance (determined by a formula including the German mark-American dollar ratio), and regular housing allowance is provided. An O-3, for example, living on the economy in the Stuttgart area will receive approximately $124.00 station housing allowance, approximately $42.00 cost of living allowance as well as his regular $206.40 housing allotment (all three items being tax free).

The availability of community resources is dependent of the size. Larger communities have European Exchange System (EES) facilities to include a post exchange (PX), commissary, foodland, linen exchange, post office, theater, bank, and a Stars and Stripes (book store). The smaller communities will usually have a foodland, theater, and a Stars and Stripes. In order to drive an automobile in Europe, a European drivers license must be obtained. The drivers test is written and consists of a rules and situation section and a road sign identification section. The smaller communities usually have an elementary and junior high (K-9) with senior high adolescents bussed to high school. Each high school services a large landmass with travel time from bus stop to school ranging from five (5) minutes to ninety (90) minutes each direction.

STRESSES OF EUROPEAN LIVING

On the surface it may appear that the possibility of a minimally stressful community life in Europe is easily attained. The European community, however, places multi-dimensional stresses on the life style of its members. Using Maslow's (1971) hierarchy of needs theory, let us identify the stresses placed on four general groupings and some specific subgroupings. The four general groupings are: (1) single, divorced, separated or unaccompanied and enlisted or NCO; (2) single, divorced, separated or unaccompanied and officer; (3) married and accompanied, sponsored or non-sponsored, and E-1 through E-5 or O-1, O-2; and (4) married and accompanied, sponsored or non-sponsored, and E-6 through E-9 or O-3 through O-9. In order to understand the stresses unique to each grouping, a more indepth plunge is necessary.

Category 1 or the single, divorced, separated or unaccompanied and enlisted or NCO individual tends to have, on the whole, less stress initially but whose defensive armor begins to corrode as his tour progresses. Leaving his peer group, family members and many love objects, this individual must collect some possessions, process-out of his former unit, usually re-establish family connections while on leave and report to his departure point where a 10-hour wait may be forthcoming followed by a 10-hour flight. The re-establishment of family connections alluded to above differs with the single, divorced versus separated, unaccompanied subgrouping. The single or divorced individual has either never made the matrimonial walk or has severed the contract. Dating relationships may have been established which cause separation pains but, in most cases, does not chisel at the psyche as it does the separated or unaccompanied enlisted or NCO individual. The separated soldier tends to dwell on the unresolved and his "here-and-now" orientation is fantasy filled. The unaccompanied soldier travels throughout the E-1 through E-9 rank structure in a bi-modal manner. The young soldier (E-1 through E-4) cannot get command sponsorship; therefore this economically straps many soldiers and prevents the accompanied tour. The older soldier (E-7 through E-9) tends to be well established within a CONUS community, often times home dwellers with children established in school and chooses to accept the 24-month unaccompanied option rather than the 36-month accompanied option. The latter usually pinches pennies, lives a rather restricted existence, delaying his gratification for a 30-day leave stateside in the middle of his tour. This subgrouping tends to sniff each other out and form a tightly knit group which has earned the title of "homesteaders" amongst their peers. In comparison, the former moves in either a negativistic-ambivalent or active-detached direction (Millan, 1969) with drug addiction, sexual acting-out and physical confrontations prevalent. Consequently, Category 1 individuals on the European-bound plane bring different agendas to their new assignment according to their marital situation. Apart from the marital situation, add-on stress tends to occur following their departure from the plane at the Rhein-Main Air Force Base. Not only does jet lag have a physical hold on the individual, but the length of the journey psychologically confirms the permanence of the CONUS separation. Following their arrival at Rhein-Main AFB, processing begins at the 21st Replacement Battalion and the actual European unit assignment is verified. Accompanied by a rail ticket, he is bussed to the train station where he is responsible for correctly boarding and departing the train so as to arrive close to the assigned unit. This may sound like a basic task, but try it not knowing the language. After arriving in the correct train station and completing the phone call to the unit C.Q., the soldier is finally united with his new unit. Now, the physiological needs of food, water, sleep!! but not sex are assured. However, for those whose adaptability is weak, the chiseling process is about to commence. Due to the language barrier, the life space (Lewin, 1935) shrinks placing an uniformity-type stress on the mess hall food, PX clothing and barrack's foot lockers and bunks. The identity pursued through restaurant hopping, different apparel and room decor is severely threatened due to language barriers, limited PX offerings, and

barrack regulations. In addition, the automobile, serving both as a status and escape symbol, further restricts movement as the Category 1 individual, regardless of marital status or age, is regarded as "single" and is subjected to exorbitant insurance rates. A 28 year old, separated, E-6, male soldier, for example, purchased minimum collision and liability insurance for his 1971 Chevy van at an annual rate of $1,200.00. Two months later, he sold his car and purchased a European style bike which he uses for transportation around the post. Interestingly, the status and escapist qualities often credited the automobile is displaced to audio-photo equipment (Stateside horsepower comparisons become wattage per speaker challenges). The soldier will return to his room following work and "reconnect with the real world." A recent survey conducted by the author revealed within the last year, the soldiers occupying the medical company of 5th General Hospital had purchased $42,500.00 worth of audio-photo equipment or a mean purchase of $850.00. These same men also indicated that a 2:1 Stateside to Europe visitation ratio existed. Before a conclusion is written to Category 1, a psychologist would be remiss if he failed to include the effects of self-esteem and love loss on the sexual trends of the soldier. Economically, the location of prostitutes near the entrance to major parts has confirmed the principle of supply and demand. In addition, one soldier, speaking hyperbolically (I assumed), made the following statement: "Latent homosexuality becomes blatent homosexuality." Not having access to actual data, let it suffice to say that sexual deprivation has seemed to have found its organismic resolution in many different ways. In conclusion, Category 1 individuals are stressed by a language barrier, high insurance rates, limited dating opportunities, long work hours, and limited PX offerings which impinge on one's pursuit of an identity separate from society's "issued" one.

Category 2 or the single, divorced, separated or unaccompanied and officer individual generally have less stress placed on them than the Category 1 soldier. Their rank places them in Bachelor Officer Quarters (BOQ) which are usually removed from their work situation. Similar mess hall and limited PX offerings stress the Category 2 individual but his options are greater. His room tends to be more private and spacious, insurance rates within his grasp, and European travel, usually in groups, pursued. A similar single, divorced versus separated, unaccompanied subgrouping as Category 1 is present; however, the economic resources of the officer usually reduces the percentage of unaccompanied officers. In addition, single school teachers can join officers' clubs thus providing another dating outlet not afforded the Category 1 individual. Stress, although similar in most cases to Category 1 individuals, is significantly diminished due to better economic resources and living conditions which allow more self-esteem and love needs to be met.

As we have seen similar stresses are placed on the Category 1 and 2 individuals, likewise a similar comparison can be made between Category 3 and 4 individuals. Unlike his Category 1 and 2 counterpart, the Category 3 or married and accompanied, sponsored or non-sponsored, and

E-1 through E-5, O-1 or O-2 individual usually has more initial stress caused by early marital separation and economic insult. If housekeeping has been pursued Stateside, then the tedious separating and packing procedure is implemented. The couple must make choices as to what to send or store based on limited information. Usually, non-concurrent travel is authorized and pursued following the temporary relocation of the family. An important distinction and consequent stress is placed on the Category 3 individuals depending on the sponsored or unsponsored nature of their assignment. If unsponsored, the soldier must incur the price of the plane fare and plan on off-post housing for the entire duration of his tour. The non-concurrent travel-based individual upon arrival at his new assignment (having a similar stressed trip as described in Category 1) must now pursue economy housing in addition to processing in and beginning work. Once an economy address or authorization for temporary quarters has been obtained, the paperwork for dependent travel can be initiated. The dependent must coordinate her whole baggage, and in some cases, household goods after receipt of this paperwork. Consequently, her remaining days in CONUS tend to be stress-filled. Add-on stress begins when either the language barrier of economy quarters or the condition of temporary quarters confront her. She is not afforded a healthy rationalization of "only" temporary as, i.e., in the Stuttgart area the waiting list is approximately 13 months for a two bedroom on-post dwelling (a dwelling only offered to sponsored individuals). The stress removed upon the marriage with his unit for Category 1 and 2 (physiological and safety) become primary stresses for the Category 3 individual. Connections with household supply must be made and an order placed for household furnishings to supplement their whole baggage and household goods. If an automobile has been shipped, a three day trip (administrative absence authorized) must be made to the northern part of Western Germany to secure the vehicle. Prior to securing the vehicle, the car owner must prepare for and pass an examination given by the military (90% criterion) on European driving regulations and road sign meanings. If an automobile was not shipped, a "clunker" is usually purchased as a means of getting to work as well as the shopping areas. Until on-post housing is obtained, the stress tends to be cumulative. Many dependents fail to reach the on-post period as the stress causes clinicians to observe the gamut of DSM-II classifications. If the on-post housing does become a reality, a false reprieve may be facing the new occupant. Stairwell living as described in Section 2 places large masses of people who are already under stress in a confined area. You need simply to refer to our sociology friends to predict the outcome. The Category 3 individual, consequently, must remove himself from his CONUS dwelling and subject his family to over a year (2 years in the non-sponsored case) of transition. Physiological and safety needs predominate in a restricted life space (in some cases hours upon hours of living in the apartment enclosed in a self-erected "cage") with little room for the development of self-esteem and love needs because of economic and psychological strife.

The Category 4 or married and accompanied, sponsored or non-sponsored, and E-7 through E-9 or O-3 through O-9 individual usually has the economic

resources to avoid the cumulative stress of the Category 3 individual. The initial stress of sorting and packing tends to be more stressful as the individual has accumulated more love objects. Consequently, the stress of seeing one's possessions placed in large boxes destined for a 36-month plus storage period tends to be traumatic for the Category 4 individual. As in CONUS assignments, rank is a determining factor in housing placements. Waiting periods for Category 4 individuals, on a whole, is drastically reduced. In addition, the adaptability of the dependent is usually established as experience is gained in moving. Similar stress as faced by the Category 3 individual in fusing whole baggage and household goods with supplementary household furnishings plus securing the family car await the Category 4 individual. However, experience plus economic factors will usually reduce the tension. In addition, the thought of extensive European travel has a greater chance for reality which offers a future orientation somewhat healthy in outlook. Being older and having higher rank usually elevates community visibility and can allow family tension to generalize to community levels. Delinquency, if off-post, becomes the responsibility of the German police. Many cases have been resolved simply by the family agreeing to terminate their tour and return to CONUS. Consequently, if any potential embarrassment to command exists, the serviceman receives the pressure (as the U.C.M.J. only applies to the active duty soldier). Category 4 individuals, free from mild to severe adolescent reaction patterns in their children tend to have less stressful tours than do their Category 3 counterpart.

The author has spent much space attempting to delineate four categories of soldiers within the European based troops. Stresses on the Category 1 and 2 individual quickly move from a physiological and safety basis to a self-esteem and love level whereas the Category 3 and 4 individual must dwell on the physiological and safety level and slowly erect the self-esteem and love levels. This foundation should illustrate the multi-dimensional aspects of stress prevalent in the European communities. The need for a community-based mental hygiene team arises from these stressful conditions. A close look at the proposed regulation should provide insight into European mental hygiene trends.

MENTAL HYGIENE: EUROPEAN STYLE

A revision of USAREUR Reg. 40-370 is presently in draft form which would drastically alter the mental hygiene structure in Europe. Each USAREUR MEDDAC will establish a Mental Hygiene Consultation Service (MHCS) with the chief being a qualified psychiatrist. The Chief, MHCS, will report directly to the MEDDAC commander. Under this MHCS umbrella, every military community served will receive a Mental Hygiene Clinic (MHC). The Chief, MHC, will be either a psychologist or social worker. The MHC staff will be determined by the size and nature of the population served. All military or civilian behavioral science personnel will be assigned to the MHC with the only exception being hospital assignments. The functional responsibilities of each MHC will include all therapeutic counseling and

outpatient treatment of emotional and personality problems, mental disorders, including those conditions involving or characterized by the abuse of drugs or alcohol. Each MHC will be responsible for all troops and troop units, dependents, Department of Army (DOA) civilians, and other personnel authorized care.

In essence, the CEDDAC or European Drug and Alcohol Program, previously a pawn of command, would be responsible to the MEDDAC chain of command. The major advantage of this realignment is increased professional supervision and, consequently, better patient care. A community-based treatment program reduces the distance required to seek treatment (in some cases 2 hours each way), increases unit-level command and MEDDAC communication channels thus opening the door for implementation of a consultative model. Crisis intervention becomes a more realistic possibility as the professional team is on-call within a given community rather than responsible for the entire MEDDAC area. Finally, continued educational programs directed by a designated chief can be implemented in an organized rather than a shotgun fashion.

If implemented, the revised USAREUR Reg. 40-370 would have to go through a transitionary phase. However, it is based on sound mental health principles and with community-minded professionals implementing the program should quickly shift from the transitionary to stationary phase.

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PSYCHOLOGICAL ASPECTS OF ARMY FIELD FEEDING

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As part of a project to study field feeding concepts for the Army and Marines, the Behavioral Sciences Division has dealt with human factors analysis of the equipment used in field feeding operations, and with the attitudes of both food service workers and customers concerning field feeding. The paper presentation at Denver was mainly a visual one centering around a series of slides depicting field feeding operations in both desert and forest environments. The areas specifically covered in the presentation included a mobile field kitchen trailer alternative to the present kitchen tent, the standard M-2 field kitchen burner unit which has some safety related problems, and consideration of disposable alternatives to the present metal mess kit.

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PREDICTION OF MILITARY POLICE PERFORMANCE IN HANDLING INTERPERSONAL CRISIS SITUATIONS: INDICATIONS FOR TRAINING AND FOR DEVELOPMENT OF SELECTION PROCEDURES

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An earlier paper (Rath, 1973) described the men of one military police company (N=111) as a psychologically healthy, varied group with an unremarkable distribution on a measure of psychological defensive style (Byrne's Repression-Sensitization Scale, 1963), tendencies toward lower frequency and intensity of interaction on a measure of interpersonal orientation (FIRO-B, Schultz, 1958) and an adjectival self description (Welsh's ACL Intellectence and Origence Dimensions, 1972) focused on extraversion with irregular attitudes and a preference for excitement.

This paper expands upon the findings presented earlier (Rath, 1974) of initial non-parametric analyses relating the personality measures to ratings (5 point-forced normal distribution) by at least three of four supervisors on the junior enlisted men's (N=80) capability to deal with people in crisis situations. The specific instructions were to rate

> "...the patrolmen's capability in dealing with people in crisis situations, considering such factors as positive action, self control, interest in people and interpersonal skill. Consider only capability in dealing with an interpersonal crisis and not performance of unrelated military functions."

The criterion ratings were obtained nine months after administration of the personality measures. The means for the various personality and demographic measures, by MP performance level, are presented in Table 1.

One clear cut finding is the over-representation of the better educated men (one year of college or more), and under-representation of the less educated men (high school graduate or less), in the highest performance group; that is, 60% of the high performers were "high" education, and only 40% "low" education; even more marked is the finding that 33% of the "high" education Ss were high performers, while only 11% of the "low" education Ss were. Thus, a man with one year or more of college was three times as likely to be rated as a high performer than was a man with only a high school diploma or less.

Looking at the interaction of performance level (high and low extreme groups) and education level (dichotomous), the greatest differences on personality measures were found between the high performance groups of differing educational level (only three groups were formed as the hypothetical high education-low performance group had only one member). That is, the high education-high performance Ss scored lower on the Repression Sensitization Scale, were significantly more likely to have a dominance of "expressed" over "wanted" interpersonal orientation scores (FIRO-B), and were significantly less likely to have a high origence-low intellectence adjectival self description than did the low education-high performance Ss. This leads to the conclusions that the social skills and intellective factors associated with educational achievement are positively related to military police performance, and that personality factors are more important to the performance level of the low educational military police than they are to the higher educated military police. The greatest similarity on the personality measures was found between the high education-high performance Ss and the low education-low performance Ss thus indicating that it is best if low education MP's don't emulate the personality style of their better educated counterparts.

When looking within the lower educational military police group and using three levels of performance (low, medium and high), it was noted that the low performance Ss tended to score at the extremes of defensive style (i.e., either repression oriented or sensitization oriented) which indicates a certain inflexibility and less adaptive style, and to score higher on need for expressed inclusion and affection, which can be interpreted as a tendency to be too eager, to be nice, and to be liked. Within this same low educational group the high performance MP's tended to have a dominance of "wanted" interpersonal orientation scores over "expressed" interpersonal orientation scores, this being interpreted as a tendency to be more sensitive to the needs of persons dealt with rather than imposing their own needs.

Since the earlier statistical analyses involved non-parametric techniques (Rath, 1973, 1974), it was considered desirable to conduct multivariate analyses on the personality measurements using wider rating ranges to establish performance categories. When 72 Ss were categorized on performance as either high, medium or low, no significant differences were found on demographic variables of age, rank, and time in service, nor were significant differences found for the ACL measures of Total number checked, Origence and Intellectence. When looking at the six FIRO-B scales and the four ACL Welsh subscales, the findings approach statistical significance (multivariate $p \leq .06$). The univariate tests of control-expressed and control-wanted achieved significance both with ($p \leq .04$ and $.05$) and without ($p \leq .01$ and $.08$) covarying education.

Thus, one demographic variable (education) and two personality variables (interpersonal orientation on control-expressed and control-wanted) are the best predictors of the performance level (low, moderate or high) that a junior enlisted MP will demonstrate. The high performance group appears to be made up of MP's with strengths in one of two qualitatively different

approaches: the "cognitive approach" of the higher educated MP, the high performance apparently based upon the general social skills and intellective factors correlated with attaining at least one year of college education; and the "interpersonal approach" of the less educated MP, the high performance apparently based upon a balanced approach toward interpersonal control issues. That is, this latter group of high performers demonstrate a stronger control orientation, both in exercising responsibility and making decisions, and in wanting responsibility and decision making exercised by others; these high performers tend to assume that a relationship has a sense of order to it, that the individuals involved mutually understand their respective roles and they act accordingly. An alternative, less likely (but not ruled out) explanation for these findings is that the criteria ratings were based not on ability to assist people but rather for controlling potentially explosive situations and avoiding untoward incidents and resulting problems for the organization (MP unit).

To further evaluate the predictive value of the measures observed to have high correlation with MP performance, multiple regression analyses were run, using selected dependent variables (demographic and personality) which had sizeable correlations with the criteria but low intercorrelation with the other selected dependent variables: these were education, control-expressed and control-wanted (FIRO-B) and four measures from the ACL, Welsh's scale A4 (high intellectence, low origence), Welsh's Origence and Intellectence dimensions and total number checked. Using all Ss and varying combinations of the highly selected predictors, the R^2 values ranged around .8, while with low education Ss only the R^2 values ranged from .2 to .3.

The findings of this preliminary study indicate useful potential for assessment of military police potential with personality and demographic measures, not simply for a yes-no selection decision but for placement in differential training programs, for development of differential military police procedures best suited to the individual MP's particular strengths and for development of assessment center techniques to initially identify and continue to monitor the individual MP's strength and deficit areas.

Follow-up validation studies should use multiple criteria measures to include not only supervisors' ratings but qualitative data such as the number of incidents and number of commendations per calls handled as reflected in the PMO log book, and ratings of the handling of assessment center situations.

TABLE 1

MP Performance Level and Means on Personality and Demographic Variables

	MP Performance Level		
	Low	Moderate	High
Range of Mn Performance Criterion Ratings	3.7-5.0	2.5-3.3	1.0-2.0
N	16	32	18
Age	20.3	20.5	20.9
Ed	12.1	12.5	13.2
Rank	2.8	2.8	2.9
TIS (months)	12.2	11.0	14.1
RS (Byrne's)	44.8	40.3	35.7
FIRO-B scales			
Ae	3.6	2.8	3.3
Aw	3.5	3.2	4.0
Ce	2.1	3.2	4.4
Ce adj for Ed	-0.5	0.5	1.5
Cw	3.8	3.5	5.2
Cw adj for Ed	6.9	6.6	8.1
Ie	4.9	3.6	4.2
Iw	4.0	3.4	3.8
Welsh Scales			
A1	54	54	55
A2	47	47	50
A3	47	50	51
A4	43	47	52
0	10.6	4.5	1.9
I	-11.7	- 9.2	-4.4
Creativity scale (Rath)	20.6	23.0	25.9
Total Adj checked	49.2	54.0	62.7

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POSSIBLE IMPACT OF ARMY PLANS FOR FY 75 - FY 80 ON PSYCHOLOGY IN THE ARMY

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I. Probable Changes in the Army

A. Army size will remain at 785,000 or slightly less.

B. We will rise to 16 divisions.

C. This will be done by cutting support units at headquarters and increasing "tooth-to-tail" ratio.

D. More funds will be spent on personnel costs, reducing availability of funds for equipment and R&D.

E. R&D will be more oriented toward application, less toward basic research.

F. There will be fewer slots for civilian schooling, and the studies will be more related to specific Army needs and the primary and secondary OPMS specialties.

G. Some brigades will go to Europe without dependents coming along.

H. There will be an increasing percentage of women, both officers and enlisted.

I. Promotions from CPT to MAJ will be slow and difficult.

J. All officers outside of AMEDD, JAG, and Chaplain will have primary and secondary specialties.

K. Line officers will receive increasing training in behavioral science and new career field of 41D, personnel management with a strong behavioral science orientation, will be developed.

L. AMEDD will have fewer MD's, more paraprofessionals, less dependent care, more use of CHAMPUS, more tightly controlled management of AMEDD personnel and funds.

II. Implications for Psychology, In and Out of AMEDD

A. Slots for AMEDD will be tight and harder to justify.

B. Training opportunities will be reduced. Graduate psychology student program is eliminated.

C. More emphasis on service to troops and military units, less on dependents.

D. Little prospect of pro pay or special promotion systems for psychologists.

E. Army Research Institute is growing, with more emphasis on social and organizational psychology.

F. There is more behavioral science content in enlisted and officer schooling.

G. Personnel space limitations may constrain the race relations and drug program staffs that have emerged in recent years.

H. A new PACDA (Personnel and Administration Combat Developments Agency) is emerging at Ft Ben Harrison with significant behavioral science missions in doctrine and policy.

I. Chaplains are much more active in behavioral science field, with increasingly sophisticated training.

J. Behavioral science will be used more at the organizational level, instead of chiefly at the individual level.

K. DCSPER has a large and growing behavioral science group in its Human Resources Development directorate - and has just gotten a general officer designee, BG Johns, with significant behavioral science background and experience.

L. Army schools (branch, CGSC, War College, USMA) looking for more faculty trained in behavioral science.

M. More Army men will be married and more Army families will need services, but there may be fewer resources with which to help them.

N. More use is being made of B.S. in areas such as training, motivation, organizational development, education, etc.

O. Psychology outside of AMEDD is growing faster than psychology in AMEDD: we're no longer the primary source of expertise.

P. In equipment design, we may trade off simpler equipment requiring more training to use effectively in place of complex equipment that is easy to use but expensive to buy and maintain

Q. More and more we will be asked if our programs are "cost effective"

R. The new roles and attitudes of women, and the attitudes of men towards women in the service, raise profound psychological issues

S. Women in the Army will need many kinds of services, including psychological, medical, child-care, career development, etc. which we have not yet fully developed

T. The all-volunteer Army will present challenges in training, personnel selection, recruitment, etc. that include many interesting psychological aspects

III. SUMMARY

A. There will be increasing opportunities for psychology, especially in non-traditional, non-AMEDD areas

B. Psychological resources will be inadequate to do all that is asked or expected

C. We will be faced with difficult choices, and sometimes unrealistic expectations of what we can do, but we also face greater opportunities than ever in the past

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CHARACTERISTIC FUNCTIONS FOR VARIOUS MENTAL HEALTH SERVICES

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Mental Hygiene Consultation Service

The Mental Hygiene Consultation Service provides mental hygiene consultation services for installation military personnel, advises commanders on morale problems, evaluates and treats active duty referrals and dependents when workload permits. This service will implement command-wide integration and centralization of outpatient mental health care and psychotherapeutic treatment, counseling, and prophylactic activities. These functions will include, but will not be limited to, the provision of care for, and prevention of, the occurrence of emotional, behavioral, personality, neurological, and mental disorders including conditions characterized or involving the abuse of drugs, alcohol and other substances. Integration, supervision and administration of clinical functions relating to the above will be the responsibility of the Mental Hygiene Consultation Service in all helping areas relating to the above problems. This service works to maintain, improve and repair the mental and functional health of individuals and organizations.

The Chief of Mental Hygiene Consultation Service will be the most qualified person available to lead this service in providing mental hygiene consultation to the military community, command, and installation. The chief shall be chosen and assigned for technical supervision to the MEDDAC Commander. The chief may be chosen from the professions of psychology, social work, or psychiatry. The major criteria for the chief's selection shall be his competency in providing services needed at the installation or command concerned.

Psychology

This service is responsible for the supervision of psychological evaluations. It is exclusively responsible for the training and supervision of behavioral science specialists engaged in the utilization

of psychological tests and other instruments, such as projective techniques used as tools in personality assessment, psychological, neuropsychological, and behavioral evaluations.

The Psychology Service provides consultation to schools and other organizations regarding diagnosis and remediation of educational, emotional, and behavioral problems. It recommends programs to support the alleviation of psychological suffering, maladjustment, and educational deficit; this service also consults with parents, administrators, teachers, and other school professionals, such as counselors, school psychologists, social workers, and nursing personnel.

The Psychology Service conducts individual and group counseling and psychotherapy and provides supervision of counseling and indepth psychotherapy as conducted by other staff members. Indepth psychotherapy in this context refers to therapeutic efforts and interventions aimed at, or resulting in, the structural reorganization of the personality of the patient or client. Counseling refers to the clarification of reality issues and alternatives for decision making and/or alleviation of stress, discomfort and sub-optimal work adjustment.

The utilization of personnel with knowledge of psychological and behavioral principles and techniques in conducting therapeutic programs, such as in relaxation training, weight-loss, assertive training, systematic desensitization, etc., is a responsibility of this service. Consults to programs designed to bring about specific and limited behavior change, such as in preventive dentistry, smokers' clinics and weight-loss groups is another of its functions.

The assessment, evaluation, and recommendation of interventions regarding community mental health problem areas is provided by this service, in addition to the supervision by trained professional personnel in the use of biofeedback instrumentation. Also, the Psychology Service designs and supervises practically oriented research.

Lastly, the Psychology Service provides professional testimony as an expert witness when requested regarding sanity, the use and interpretation of psychological instruments and tests, and behavioral, emotional, and psychoneurological problems.

Psychiatry

The Psychiatric Service supervises, implements, and consults regarding the medical aspects of the operation of the Mental Hygiene Consultation Service. This service also acts as liaison to the MEDDAC hospital regarding admission of psychiatric inpatients and the management of them in the inpatient setting.

It is the responsibility of the Psychiatric Service to conduct individual and group counseling and psychotherapy, in addition to

supervision of personality counseling and treatment conducted by social workers and enlisted personnel in accordance with AR 40-4. Psychotherapy in this context refers to therapeutic efforts and interventions aimed at, or resulting in, the structural reorganization of the personality of the patient or client. Counseling refers to the clarification of reality issues and alternatives for decision making and/or alleviation of stress, discomfort, and sub-optimal work adjustment.

It provides professional testimony as an expert witness when requested regarding individuals involved in legal proceedings within the limits of his training regarding issues such as the sanity of persons.

Social Work

The responsibility of the Social Work Service is to provide social histories, individual or group counseling to minimize the social impact of illness, disability, or hospitalization upon the patient or his family and/or referral to appropriate military or civilian resources to meet the needs of individual patients. It is responsible for liaison to MEDDAC or other hospitals for purposes of unit and family contacts regarding hospitalized patients.

This service coordinates with community action agencies or supervises behavioral science specialists who do so. Examples of agencies with whom coordination is needed are: Red Cross, ACS, welfare agencies, adoption agencies, child advocacy and abuse boards, and civilian drug and alcohol agencies. The Social Work Service may conduct group or individual psychotherapy with technical supervision of a qualified psychiatrist or psychologist and provides assessment, evaluations, and recommendations regarding community mental health problem areas.

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STANDARDS FOR PROVIDERS OF PSYCHOLOGICAL SERVICES: IMPLICATIONS FOR ARMY PSYCHOLOGY

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The Standards for Providers of Psychological Services approved by APA in September 1974 have broad application to all Army Psychologists. Since these standards apply to all types of settings, Army Psychologists should not only be aware of them, but to the best of their ability should implement them, whether their work is in research, management, or providing direct services. Some of the standards which have particular reference to Army psychology are discussed.

I. Standard 1.1 defines a qualified psychologist in the following manner:

> "A qualified psychologist has a doctoral degree from an accredited university in a program that is primarily psychological, appropriate experience in the area of service offered, and either a license or certificate by state statute or endorsement by the state psychological association through voluntary certification."

The definition of a psychologist in the Army is generally in accord with this statement; however, in the past a State license has not been considered necessary. The implications of this standard for the Army psychologist include encouraging him to get a license, providing him with a statement in order to seek out support from his command for time and funds to obtain this license, and providing the possibility of upgrading services.

Another standard (2.1) states that each setting offering psychological services shall have at least one qualified psychologist available.

II. Concerning supervision, Standard 2.2 states "Providers of psychological services who do not meet the requirements for the qualified psychologist shall be supervised by a qualified psychologist."

This is a very clear statement, indicating that people who are not "qualified" psychologists must be supervised by one who meets the qualifications outlined in Standard 1.1

III. The standards are very clear in their statement about the need for written statements of objectives and policies, procedures for delivery

of psychological services, and a description of the lines of responsibility. Furthermore, Standard 3.3.2 states "There shall be a written service delivery plan for every consumer for whom psychological services are provided."

This is a very important standard, even though there has been considerable discussion about its meaning and application. It means that it is not only important to have a record of what services have been provided, but that a plan needs to be developed concerning what is going to be offered to the consumer (or client or patient) and how the services are to be delivered. Under the interpretation of this standard, the following statement is included: "Although the format will vary with the setting, a written plan which will analyze the problems, set priorities among established goals, and outline systematic procedures for implementation of the plan is necessary for the effective delivery of psychological services."

IV. The standard concerning confidentiality is similar to that principle in the Ethical Standards of Psychologists, and 3.3.4 states, "Providers of psychological services shall establish a system insuring the confidentiality of their records."

This standard provides the Army psychologist with some difficulty, but every effort should be made to apply it to the practice of psychology in the Army. In the interpretation section there is an explanation that consumers should be informed of any limits of the maintenance of confidentiality, and further that the client or patient should be apprised concerning the people who might have access to the information he is giving. It further stresses the point that all persons supervised by psychologists should be instructed concerning the importance of confidentiality.

V. The standards very emphatically stress the matter of accountability, and the necessity of systematic and objective evaluation of psychological services. Perhaps the strongest statement concerning accountability is Standard 4.4 which states "Psychologists are accountable for all aspects of the services they provide and shall be responsive to those concerned with these services." Furthermore, these standards stress the fact that a psychologist belongs to an independent, autonomous profession and should be aware of his responsibilities for development of the profession, even though the psychologist is encouraged to work in cooperation with other professionals for the benefit of the consumer.

The above standards are some of those that were discussed, although the discussion did include many others which apply to Army psychology. Army psychologists are encouraged to keep a copy of these Standards readily available, provide copies for those who have a need to know this information, including members of their staff, their supervisors, and the consumers they serve.

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NEW DEVELOPMENTS IN HEALTH CARE REGULATION

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New developments in licensing and other means of health care regulation are of great interest to psychologists both directly and indirectly. The existing health care delivery system has been ineffective in the view of most consumer advocates and many congresspersons. As a result, the consumer reform movement has hit the entire health care field with a vengeance. Psychologists have not been spared, and they must expect even more changes to come.

The pressures for change and their sources are not only real and identifiable, they sometimes make conflicting demands. There are powerful elements of the Congress and the Department of Health, Education, and Welfare in which the obligation to serve the public better is taken very seriously. To many of us, dedication of government to the good of the public is a refreshing novelty. However, no matter how much we may support health care reform, some aspects of impending change promise to be difficult. Better service to the public is sometimes seen as requiring higher standards of practice at the same time that it requires lowering standards to permit greater ease of entry into the field, among other conflicting demands.

The will of Congress is felt directly in such legislation affecting the federalization of health care as CHAMPUS, Medicare, and the pending National Health Insurance. It is also felt less directly but no less strongly when strings are attached to Federal funding of crucial programs. Among the latter are such things as provisions which would, effectively, set national standards for licensing of health care providers as a prerequisite to availability of funds for health manpower training. More recently the same provisions have been attached to a bill which would provide funding for the proposed malpractice insurance pool.

The Department of Health, Education, and Welfare is another source of pressure for change. In 1971 DHEW adopted as official policy a report on health care credentialing which has several provisions of importance to psychologists. It is the basis for the proposed national standards. First, it calls for the consolidation of licensing boards regulating all health care professions within a state in order to insure

uniformity of standards. Second, it would require that persons presently exempt from state licensing requirements because they are employed by an institution be required to be licensed. Third, ladder and lattice concepts would be introduced into health care, requiring that advancement within and between health care disciplines be contingent upon experience and demonstrated competence. These latter requirements are addressed directly to the restrictiveness and exclusiveness of some boards which effectively keep many aspiring health care providers out of the field. How to construct the necessary examinations has not been addressed. Fourth, mandatory continuing education and/or periodic relicensing provisions would be required for all professions.

Since all these restrictions are seen as alternations in state licensing requirements, State Boards of Psychological Examiners would be the direct implementers of change, and those boards tend to be conservative, relatively uncoordinated, and slow to move. As a result, the field may well be in a state of confusion for some time, and other means may be required to provide some of the services needed for maintaining the credibility of the profession.

An example of the latter is the National Register of Health Service Providers in Psychology. First, private health insurance carriers and then government agencies and legislative aides have raised the problem of identifying psychologists who are qualified to render health services. Licensing has not helped with this task since virtually no psychology licensing laws distinguish among psychological specialties, and it could take as much as 10 years to achieve anything like nationwide specialty licensing for psychology. Obviously, if psychology is to be included in national health insurance and to make progress toward reimbursability with private third party carriers, some strong step had to be taken much sooner than the states could be mobilized to effect changes in their laws.

The APA Board of Directors asked the American Board of Professional Psychology to produce a national register of health service providers in psychology. ABPP formed the National Register Council which set standards for inclusion and assumed the job of screening. In just one year the first volume of the Register has appeared, including some 7,000 psychologists, with provision for regular updating as other persons apply. Standards for inclusion in the Register are being written into Federal laws governing reimbursability. Production of the Register has revealed even more inconsistencies among state licensing laws than was expected.

Continuing education is another of the areas in which progress toward meeting expectations has been slow but is now getting off the ground. Eight states now require or are considering legislation requiring evidence of continuing educational experience for license renewal. Others will follow, but whether they can or want to move fast enough to avoid government intervention is questionable.

Although APA's primary mission has always been continuing education, in the broader sense it has not been active in pushing requirements for participation nor in encouraging the development of locally available continuing educational opportunities. In that respect, they have been well behind medicine, where most specialty boards have continuing educational requirements.

At this point efforts are being made to institute an office of continuing education within APA which would be charged with stimulating activity in this area. If we don't move quickly we will have little recourse when government standards are imposed on us.

In some areas we have been more active as a profession and can be pleased, even if our activity imposes some constraints on us. We have established the mechanisms for a voluntary peer review system well ahead of schedule. The ability to move into Medicare or National Health Insurance with a PSRC (Professional Standards Review Committee) system which will permit psychology to monitor its own quality and cost of services should not only facilitate inclusion of psychology services, but also it will help preserve autonomy.

The Committee on State Legislation of APA has been active. It has recommended that APA support the extension of licensing requirements to persons employed in presently exempted positions. That will no doubt post some awkwardness for public institutions as well as for individual psychologists, but ultimately it should raise the standards for service and clarify the nature of practice in psychology.

The Task Force on Standards has captured many of the current demands and posed a real challenge to professional psychology in its proposal for new standards. It is time for psychology to come to grips with the problems of quality service. Unless we do it voluntarily, promptly, and through familiar, established institutions, we can expect to be less and less autonomous and more and more controlled by very identifiable forces outside the profession.

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RATIONALE AND FORMULATION OF A SHORT NEUROPSYCHOLOGICAL TEST BATTERY

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Introduction

The clinical application of neuropsychological assessment procedures is usually directed toward two primary goals. The first of these is diagnosis of various kinds of brain dysfunction (Filskov and Goldstein, 1974; Reitan, 1955; Vega and Parsons, 1967). The second goal, and of paramount importance from a psychological standpoint, is the delineation of an individual's unique pattern of behavioral strengths and weaknesses so that appropriate recommendations for maximal interpersonal and environmental adaptation may be outlined (Reitan and Davison, 1974, p. 17).

One of the most well-known and widely used instruments in clinical neuropsychology is the Halstead-Reitan Battery (Reitan, 1955b; Reitan and Davison, 1974). Its composition includes several tests devised and researched by Ward Halstead and a number of other tests and modifications implemented by Reitan (Reitan and Davison, 1974). A vast number of research articles has been published on this battery and its components and it stands as one of the best investigated psychological assessment procedures available (Filskow and Goldstein, 1974; Reitan, 1955b; Reitan, 1964; Reitan and Davison, 1974; Vega and Parsons, 1967). In spite of its positive features, however, the Halstead-Reitan battery is subject to certain criticisms which essentially involve administrative and practical considerations serving to limit its usefulness in various areas.

One of these considerations involves the amount of time necessary for administration of the battery. In general, clinical usage has indicated that 5 to 8 hours of testing time is necessary for a proper evaluation. Additional time is necessary for interpretation and communication of the results. This time factor, therefore, can result in a significant financial obligation for the patient and can involve a significant cost to the clinician in terms of necessary manpower. Additionally, in minimally staffed clinics with heavy case loads, a situation is conceivable in which the number of legitimate requests for neuropsychological evaluations might far outweigh the availability of personnel to perform this service.

Another consideration may be thought of in terms of the size and bulk of the physical equipment in the battery. It cannot be easily transported by one examiner from place to place. This logistical problem can be especially critical in the evaluation of a hospitalized, non-ambulatory patient. Thus, the complex, bulky equipment in the battery (categories box, Tactual Performance Test Apparatus) does serve to limit its flexibility.

The third and last consideration concerns the availability and obtainability of the equipment in the battery. In many small, fairly isolated clinics and hospitals, this equipment is not available on account of its cost and the average patient load. Several hundred dollars is necessary for a full set of equipment and many less affluent clinics, hospitals, and practitioners may choose not to order this equipment. Its cost may not be justified by the number of potential opportunities for its use.

One tactic that clinicians have implemented to avoid these problems has involved the development of specific tests to discriminate individuals with "brain damage" from those without (Satz, 1964; Bender, 1938; Price and Deabler, 1955). These tests, however, lose a great deal of information about an individual's many behavioral capabilities and don't really provide any useful specification of the nature of the suspected "brain damage." Additionally, and most importantly, the concept of "brain damage" seems to imply a unitary phenomenon which operates in the same way each time it occurs. In reality, this is certainly not the case and thus, the likelihood is small that any single psychological test of cortical dysfunction can be significantly sensitive to the vast number of differing abnormal conditions that may occur within an individual's brain (Reitan and Davison, 1974, p. 14). Consequently, the usefulness of any single neuropsychological test as opposed to the battery approach is questionable.

This clinician believes that the dilemma outlined above can be satisfactorily resolved with a shorter, less complex neuropsychological battery that could best be labelled as a screening battery. Such a battery would ideally require less time for administration and scoring than the full Halstead-Reitan battery thereby reducing the cost of administration in terms of both money and manpower. Also, this screening battery should be physically compact and easily transportable from one place to another by one person. Finally, this battery should be composed of simple, inexpensive paper and pencil tests which would be available or easily obtainable in most clinics and private offices.

Presentation and Discussion of the Battery

Such a neuropsychological screening battery has been recently developed at Walter Reed Army Medical Center by the author of this paper. The components of the battery, labelled the Walter Reed Neuropsychological Screening Battery, are as follows:

The Shipley-Hartford Institute of Living scale to include both the CQ (Shipley, 1939) and WAIS equivalent IQ (Bartz and Loy, 1970).

The Wechsler Memory Scale, Form I - subtests III, IV, VII (Wechsler, 1945).

The Aphasia Screening Examination used by Reitan (Reitan, 1969).

The Finger Tapping Test used by Reitan (Reitan, 1969).

A Sensory Perceptual Examination devised by this author to test for extinction to bilateral simultaneous stimulation, finger agnosia, fingertip number writing misperception, and asterognosis (details available on request).

The Bender-Gestalt copy phase (Bender, 1938).

The Trail Making Test as used by Reitan (Reitan, 1958; Reitan, 1969).

The MMPI

Optional tests are also included in the battery and may be administered if time and equipment considerations permit. These tests are as follows:

The Canter Bender Interference Procedure (Canter, 1966).

The Smedley Hand Dynamometer as used by Reitan (Reitan, 1969).

The process of composition of the battery was primarily guided by the author's knowledge of and experience with assessment in clinical neuropsychology. The goal of this process was to formulate a battery of tests which would adequately assess most major areas of behavioral functioning covered by existing batteries. Familiarity with the Halstead-Reitan battery provided a major input for this formulation. Additionally, clinical experience with a neuropsychological battery developed by Paul Satz at the University of Florida provided valuable information. Finally, the most salient input for this formulation resulted from Davison's conceptual framework for organization of test variables into groups representative of general categories of behavioral functioning (in Reitan and Davison, 1974, p. 329 ff.). Davison's groups together with the tests in the screening battery appropriate to each group are as follows:

Pure motor skill—finger tapping, dynamometer

Tactual perceptual—sensory-perceptual exam

Immediate alertness-Wechsler Memory Scale subtest II

Auditory Perception—not covered

Tactual motor problem solving—not covered

Visual-spatial and visual-sequential abilities—Trail Making Test—Bender-Gestalt

Verbal abilities—Shipley-Hartford, Aphasia Screening

Incidental Memory—Wechsler Memory Scale—not a specific test of incidental memory but closely approximates with a delayed memory component on IV (Milner, 1964)

Summary IQ measures—level of education, occupation, Shipley-Hartford IQ equivalent (Bartz and Loy, 1970)

Reasoning, Concept formation, organizational ability and flexibility in applying principles—Shipley-Hartford, Trail Making Test

Academic Ability—level of education Shipley-Hartford

As is evident from the above display, 9 of the 11 major areas of behavioral functioning listed by Davison are assessed by the screening battery. Such a broad coverage of human behavioral functioning in a test battery designed merely for screening purposes would seem to provide considerable support for serious consideration of this instrument as a useful clinical tool. Certainly, the diversity of skills necessary for successful performance on this battery and the amount of information provided in the results make its usefulness superior to single tests of "brain damage."

Certain problems, however, do arise when one compares the utility of this battery to that of the full Halstead-Reitan battery. With fewer tests in the battery, one has less opportunity to employ the four methods of neuropsychological inference (Reitan, 1967) in order to make statements about suspected cortical dysfunction. Additionally, the screening battery provides less data with which to formulate a comprehensive analysis of the patients' various levels of behavioral functioning. Thus, the screening battery appears limited in its overall utility when compared to the full Halstead-Reitan battery.

With these considerations in mind, then, what sort of information should one reasonably expect this screening battery to provide? This author feels that this or any other screening battery should provide information on the most basic and frequently requested consultation topics. These topics as experienced clinically by this author, are as follows:

Presence or absence of brain dysfunction

Possible hemispheric lateralization of the dysfunction

Severity of the dysfunction. Severe, debilitating behavioral deficits as opposed to a more mildly deficient pattern of results.

General behavioral strengths and weaknesses noted. Speech, language and verbal-conceptual abilities vs. nonverbal perceptual-motor abilities.

Thus, utilization of this battery should properly center around situations in which temporal and/or logistical factors contraindicate use of the full Halstead-Reitan battery. For example, in a setting in which patient load far exceeds manpower availability, the screening battery might be utilized as a triage procedure to determine which patients actually require a full Halstead-Reitan battery. In clinical practice, administration of the screening battery requires approximately 1½ to 2 hours time (except for the MMPI) as opposed to the 5 to 8 hours required for the full battery. Also, the screening battery could prove most useful in time-delimited situations requiring evaluation of a patient on short notice (i.e., before surgical intervention for a recently discovered tumor). Finally, this screening battery could probably prove most useful in many private practices and small isolated clinics whose budgets and patient load would not justify purchasing the entire set of Halstead-Reitan equipment. As one can readily see, much of the equipment necessary for the screening battery is simple, relatively inexpensive and readily available to the practicing psychologist.

One final important point must be emphasized: This screening battery is in no way designed to replace the Halstead-Reitan battery in clinical practice. Certainly, the Halstead-Reitan battery would be the instrument of choice whenever possible. The vast body of literature surrounding it and the wealth of information that it provides is second to none. However, in situations such as those outlined above, this author feels that a screening battery such as the one presented can be a helpful instrument for the practicing neuropsychologist and research on this screening battery is now underway to determine the limits of its utility.

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REPORTS OF WORK GROUPS

The ten work groups with the names of leaders and members (barring last minute trades by individuals) are listed below.

Group 1 - Functions of the division psychologist, staffing guide, and S.O.P.
CPT Ernest J. Lenz, Jr. (leader)
CPT Jack E. Bentham
CPT Robert F. Smith
David Stulman
Joseph E. Peters

Group 2 - Planning for the next Current Trends in AMEDD Psychology Conference.
CPT Donald E. Pickleshimer (leader)
CPT Raymond A. Parker, Jr.
CPT William D. Siegfried, Jr.
CPT Raymond C. Graeber
CPT Paul R. Best, Jr.

Group 3 - Psychology internship direction, closer working relationship between the three internship sites.
CPT Frank H. Rath, Jr. (leader)
CPT Cecil R. Scott
CPT Thomas R. Stephenson
CPT Gary Greenfield
CPT Howard G. Atkins, Jr.
CPT William I. Dorfman

Group 4 - Procurement of psychologists for the military, alternatives to GSP and feeder system.
CPT Stephen T. Lifrak (co-leader)
CPT Larry H. Ingraham (co-leader)
CPT George A. Luz
1LT Charles K. Burdick
Dan Rickett

Group 5 - Career planning and development for Army psychologists, AMEDD versus non-AMEDD, etc.
CPT Edward G. Bleker, Jr. (co-leader)
CPT Lawrence E. Symington (co-leader)
CPT Harold D. Rosenheim
CPT James R. Siebold
CPT James W. Futterer (co-leader)
CPT Stanley H. Holgate
Neil Johnson

Group 6 - Consultation, the use of consultants to Army psychology programs and establishment of exchange programs of consultation.
MAJ Francis J. Fishburne, Jr. (leader)
CPT Dennis W. Bull
CPT Harry L. Piersma
John Fullerton

Group 7 - Training, core curricula for basic and advanced courses, 91G's, etc.
CPT Otis W. Snyder, Jr. (leader)
CPT Daniel J. Venezia
CPT Donald J. Taylor
Dr. Marjorie Kaplan

Group 8 - Political and organizational structures to accomplish goals (APA, CAPPS, Division XIX, etc.)
CPT William A. Weitz (leader)
CPT Thomas K. Saunders
LTC Cecil Harris
Terry Orme
Bill Wirt

Group 9 - MHCS staffing guide revision (DA Pam 570-557, Jun 74) to make MOS immaterial for Chief, MHCS.
CPT William J. Wisniewski (co-leader)
CPT John D. Shoberg (co-leader)

Group 10 - Revision of 201 file in order to reflect appropriate areas which are now neglected.
CPT David H. Gillooly (leader)
MAJ Elliott R. Worthington
CPT Thomas R. Stephenson

Three psychology officers were not in any specific work group but were floating among all ten. LTC Hartzell and COL Nichols were consultants and resource persons to all ten groups upon request and floated from group to group as needed. CPT Zold, who organized and supervised the formation of the work groups, also visited all the groups in order to check on the work in progress. Additionally, there is no record of the work group membership of 11 attendees:

CPT Clifford R. Dempster
CPT Frederick S. George
CPT Kent A. Kimball
CPT John A. Martinez
CPT Robert C. Hulsebus
CPT Ronald C. Peterson
CPT Walter F. Powers
CPT Michael G. Sanders
1LT John A. Petzelt

AD P003723

INTERNSHIP TRAINING WORK GROUP

Leader: CPT Frank H. Rath, Jr.
Chief, Psychology Service & Internship Programs
William Beaumont Army Med Ctr, El Paso, TX

Work Group Report

The following report was written by the group leader several weeks following the conference and distributed to all work group members and the Psychology Consultant.

1. Work group membership: Captains Gray Atkins, Bill Dorfman, Gary Greenfield, Frank Rath, Dick Saunders (for consultation), and Rod Scott.

2. There were two main concerns of the work group: how to improve and achieve a better fit between interns, internship sites, and the demands of military service following completion of the internship, and to initiate a better sharing of resources among internships and from psychologists outside the internship settings.

3. The following general assumptions were made: the interns currently in the Graduate Student Program are from clinical/counseling doctoral programs and have continuing interest in these areas; the three internship settings are either accredited or seeking accreditation by the APA as clinical/counseling internship sites and this implies that graduates of the programs will have achieved at least minimum skill levels in selected traditional core areas; and if there is any significant change in the direction of training and experiences provided at the internship sites, such as a predominant focus upon organizational development or application of social psychological skills, it would be necessary to change from a pre-doctoral clinical/counseling internship to, for example, a post-doctoral fellowship program.

4. To better ensure an intern-internship setting fit, the solicitation of information from interns and provision of information to interns should be on a collective basis, with the cooperation of the SGO Psychology Consultant and each of the three internship settings. Therefore, rather than each internship setting having its own completely individualized description, it is recommended that a common description of the Army Internship Program be developed in time for use with prospective interns for the 1975-1976 training year, to include the description of core skills (see paragraph 5) and then individual descriptions of each of the three internship programs describing their particular settings, staff orientations, and strengths which lend individuality to each of the three internship programs. It was further recommended that when this material is forwarded to the prospective interns that appropriate vitae be

included on each of the internship staff members so that prospective interns could more appropriately evaluate the internship settings to decide which might be most appropriate for them. These vitae would include professional background, current interests and activities, and orientation within each activity area; e.g., individual therapy, RET (or psychoanalytical, etc).

5. The work group identified core areas which all three internship settings consider essential for all interns. Five basic core areas were decided upon:

a. To identify and develop effective interventions with person problems, ranging from acute crisis situations to severe psychopathology;

b. To assess and develop intervention plans for organizations/ institutions in distress/stagnation, and implement the intervention;

c. Program evaluation and/or assessment of professional activities to determine effectiveness and course of future action;

d. Intra/interpersonal awareness and development;

e. Teaching/training of diverse populations to include technicians, sub-doctoral psychologists, administrators, managers, etc.

Further, it is desirable that each intern develop specific, strong core intervention skills in at least one of the core areas a, b, or c. Gray Atkins volunteered for the task of these core skill areas delineating a range of specific skill foci within each core area and eliciting concurrence from each of the three internship settings; a target date of 1 Feb 75 for the completed core description has been established.

6. Consistent with developing the coordinated information provided to prospective interns, it was decided to develop a common modality for gaining information concerning the backgrounds, skill levels, and interests for future training/professional development in activities of each of the prospective interns. At the present each internship site solicits information from interns only after they have been selected for assignment. It was recommended that a common questionnaire be developed for prospective interns which would be forwarded to prospective interns to be returned prior to selection for the given internship settings, with copies of each completed questionnaire provided to each of the three internship settings and the Psychology Consultant. Frank Rath was designated to coordinate the development of a common prospective intern questionnaire for the three internship sites, to be completed with all three internship setting concurrences by 1 Feb 75.

7. The following techniques/procedures were discussed as desirable for enhancing training at all three internship settings:

a. To individualize programs for each intern based upon prior experience, current skill level, and intended professional development/ professional activities. This is not to imply a laissez faire program.

b. Each intern should be provided regular, periodic review/critique of program progress and revision of program goals as appropriate. A quarterly review is considered minimal.

c. Each internship setting should provide a video feedback training group for the interns; this may or may not be on the "Christians-Lions" format used so successfully by Howard Bean at Fort Ord.

d. Staff-intern sharing at a real and feeling level on a one-to-one basis; this is facilitated when each intern has an advisor/advocate/ supervisor over the period of the year.

e. When the staff shares their own professional growth and concerns with their growth and future with the interns, significant intern learning and staff learning occurs.

f. The use of local professional psychologists as ongoing consultants in supervisory relationships provides valuable mid and senior level experience and alternative role models. This is most effective when the consultants selected vary on a yearly basis depending upon the particular intern's needs.

g. An exchange of internship staff/interns within the Army Internship Programs would be desirable as financially possible.

h. Having Army psychologists from non-internship center settings in as consultants would provide valuable training needs currently lacking, as there is a finite limit as to the expertise available within any one given internship staff. Again, this is susceptible to current financial constraints.

8. In attempting to improve the sharing of resources among internship centers and eliciting creative input from staff psychologists from without the internship programs, it was recommended that various skill training packages be developed for use at internship settings and also other Army psychology locations. These special skill training packages could use any of a number of modalities, to include video-tape programs, audio programs, comprehensive lesson and program plans, role playing scenarios, and compilation of resources in particular areas of interest. Each skill training package would be slanted towards providing either professional intern training or an intervention package for later use by the intern. Topics suggested for special skill package development included:

a. neuropsychological evaluation

b. sexual therapy

c. crisis intervention (emergency intervention)

d. case management

e. counseling skills

f. behavior modification

g. hypnosis

h. child evaluation

i. child therapy

j. organizational development assessment

k. organizational development entry phase

l. organizational development implementation

m. organizational development evaluation

n. group processes

o. consultation skills

p. medical psychology

q. research in applied clinical areas

r. training and teaching

s. supervision

t. assertion training

u. the treatment of stuttering

v. training and utilization of professional volunteers

w. manpower issues

This is not meant to be an inclusive list of possible skill training packages, nor would it necessarily follow that only one training package would be developed for each area; for example, several psychologists have already expressed interest in developing skill training packages for

sexual therapy, utilizing significantly different modalities. Fred George has agreed to compile a listing of resources existing already within the Army community for skill training packages and will have a target date of 1 Apr 75. Bill Dorfman will be responsible for soliciting development of skill training packages from the staffs at the three internship settings, and Rod Scott will solicit development of skill training packages from psychologists outside the internship settings; a target date of 1 Feb 75 has been established for initiating development in at least several of these skill training areas with several training packages to ve available NLT 1 Jun 75. For those outside the internship settings, reinforcement for developing packages could include ex officio appointment as djunctive internship staff members, support in resources necessary to develop the packages, and the utilization of skill training packages so that psychologists can try out their ideas.

9. It is anticipated that the selection of interns (LTC Hartzell indicates there are 15 prospective interns to start Sep 75) would be accomplished in the following fashion: internship information would be provided to each prospective intern, together with the intern questionnaire NLT 1 Mar 75; each intern would return the questionnaire NLT 25 Mar 75, to allow distribution to each internship setting by 1 Apr 75; through telephonic contact, the three internship settings and the Psychology Consultant could probably make assignments based upon gross evaluations of intern needs and interests as well as the internship settings' resources and needs; for those selections on which the agreement cannot be reached by telephone, representatives of each internship setting could meet with the Psychology Consultant at the April Behavioral Science Trends Conference in San Antonio to finalize selection. Interns should be notified of internship assignments NLT 1 May 75 to allow for adequate planning time by both the interns and the internship centers.

Status Report

Status as of 1 May 75 on continuing issues and agreed upon tasks.

1. An intern questionnaire was developed with the active participation of the three internship centers and the Psychology Consultant. The questionnaire was completed by all prospective interns, with the Psychology Consultant providing copies of each completed questionnaire to each of the internship centers. A conference call to determine assignment of interns is pending. The questionnaire content follows; spacing was provided for the actual format which is five pages in length.

ARMY PSYCHOLOGY PROGRAM INTERN QUESTIONNAIRE

Name: _____ Mailing Address: _____

_____

Date: _____ _____

1. Psychology Experience, Interests and Needs.
   When specifying interests and needs, differentiate, if appropriate, between the internship year and post-doctoral practice.

   A. Consultation (i.e., activities other than direct service to patients)
      What types of consultation training and experience have you had? In what settings?
      What are your interests and felt needs for further training and/or experience in the consultation area? In what settings?

   B. Therapy
      What therapy experience have you had (group, individual, family, sexual-marital, child)? What types of clients, how many cases, what frame of reference (behavior modification, Adlerian, insight, Gestalt, interactive, rational-emotive, etc.)?
      What are your interests and felt needs for further experience in therapy? What types of therapy and what frame(s) of reference?

   C. Assessment
      What assessment experience and skill do you have? Please indicate the types of assessments you've done (neuro-psychological, projective, vocational, intellectual, achievement), approximate numbers, and name of tests with which you are familiar, approximate number administered and interpreted, and nature of client population(s).
      What are your interests and felt needs for further experience in assessment?

   D. Research
      What experience have you had in research (applied/experimental, program evaluation, statistics, computer programming)? Please specify content areas as appropriate.
      What are your interests and needs in research? Please indicate both type and content area.
      Will you have completed or be continuing your doctoral research during the internship year (please explain)?

   E. Teaching-Training-Supervisory Roles
      Please indicate experience, both in content area and extent, and interest/felt need in developing in these areas.

2. Background Information

   A. Institutions, with degree and year awarded.

   B. Outline of Practicum Experiences in Assessment, Therapy, Consultation, and Research

C. Prior Military Training and Experience.

D. Demographic

Rank: _____ Age: _____

Date of Rank: _____ Marital Status: _____

Children (age and sex): _____ _____

_____

_____

3. General

A. What are the professional psychological skills in which you are best qualified? In which you feel least qualified?

B. What generally do you hope to get out of the internship year? What existing skill area(s) do you most want to build on? What professional skill areas do you most want to be exposed to and given the opportunity to develop?

C. Are there any special issues (family, academic, health) that will require special attention while you are in the internship year?

D. To whom in your graduate school should we write to discuss your progress as a professional psychologist? (Name and position title)

E. Considering the descriptive information on the three internship centers, and what else you might know about these, what is your preference? Please rank order with 1 indicating your first choice, and give the primary attraction of each of the three internship centers for you.

Rank Order Preference		Primary Attraction
_____	MEDDAC, Ft Ord, CA	_____
_____	Walter Reed AMC, Wash DC	_____
_____	Wm Beaumont AMC, El Paso, TX	_____

End Army Psychology Program Intern Questionnaire

2. The common description of the Internship Program is still being developed. A draft of the common core skills has been developed by CPT Atkins and is now out to the consultant and the three internship centers for review. When consensus has been achieved, each internship center will provide an additional description of its unique aspects and orientation. It is also anticipated that each internship center will provide brief descriptions of prior interns, individualized programs/ experiences and brief staff vitae. This will be forwarded as one information package to prospective interns by the Psychology Consultant.

3. Development of Skill Training Packages remains embryonic in terms of the production of formalized programs/materials available for use at all three internship centers. There are several Training Skills Packages scheduled for completion at the internship centers NLT 31 Aug 75 (e.g. two WBAMC interns, CPT Jim Thompson and 1LT Jerry Bryan, will videotape their Marital Skills Training Seminar, which is based upon the Rational Emotive approach).

Many Army psychologists outside the internship centers have developed various programs but have not yet formalized and/or reproduced the programs for use at the internship centers. CPT Rod Scott has talked with many of these professionals and senses multiple causes for this present failure, these being: putting programs in reproducible and understandable format for others would typically involve extensive effort on off-duty time as this is not continued as part of the assigned duty responsibility; concern with expending great effort while others use the product and reap the rewards; concern with appropriate use of programs developed, concern with receiving professional recognition and credit for innovations (e.g. the originator given credit by name whenever the program is used); and recognition within the relevant military structure for the achievement. These concerns will have to be met and the work group will address them with the Psychology Consultant.

CPT George is continuing to work on developing a listing of training resources already available in the Army.

AD P003724

Proceedings of Current Trends in Army Medical Service Psychology
December 9 - 13, 1974, Fitzsimons Army Medical Center

CAREER DEVELOPMENT AND PLANNING - (APPLIED AREAS)

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I. The task group limited itself to professional rather than maintenance issue and operated under certain assumptions:

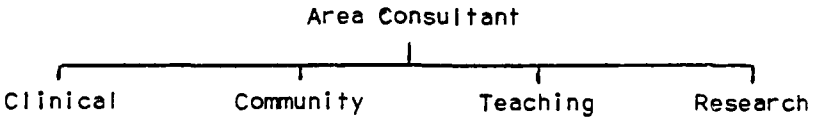
A. Army psychologists are and will be oriented toward a career in the military.

B. Psychologists in the Army have a need to view career avenues within the military which allow for development and advancement both as a psychologist and a military officer.

C. We operate in a highly structured bureaucracy which needs to be able to view psychologists in a structured career manner and psychologists need to be able to see themselves in a structured career pattern within the bureaucracy. This does not negate the need for flexibility to deal with individual needs and change within the structure. (Future Shock).

D. For career development to be an operational concept, there must be continuity in program development both at a local level and on an Army wide level.

II. There are several Functional Career Areas available within the Army at the entrance level.



A. The area consultant is a new position at the middle management level which needs to be developed. It will be further discussed in a following section.

B. The primary functional areas listed above are not hierarchial and are not necessarily exclusive but rather are intended to reflect a predominance of interest and function.

C. If an individual wishes to advance to the middle and upper level positions he should seek assignment in two or more of the functional areas early in his Army career.

III. Current positions for psychologists in the Army can be sorted on the basis of primary area of functioning.

A.

Teaching	Clinical
Academy Health Sciences	Psychology Service
Internship	MHCS (clinical slots)
Basic Branch Schools *	
Medical School *	
Senior Service Schools *	

Community	Research
MHCS (community slots)	Major Command level position for
Organizational Development	Clinical Research * (social,
Division Psychologist	industrial)
Staff Consultant *	

* new positions to be developed or expanded

B. Area Consultant

1. The area consultant would act as the primary consultant to all psychologists in his area and to the Command Staff.
2. The term area is yet to be defined. It could refer to Major Commands such as TRADOC and HSC or to regional health areas.
3. The individual holding such a position might also hold another position such as Chief of Psychology at an Army Medical Center, at least until psychology develops further in the Army.
4. This position might eventually develop into a non-AMEDD position.
5. In addition to coordinating psychological activities in his area, the area consultant could also serve as a primary contact for the SGO consultant. (This establishes a psychology chain of command).
6. The figure below conceptualizes the area consultant:

SGO Consultant

Area Consultant	Area Consultant	Area Consultant
Clinical	Teaching	Community
Community	Clinical	Community
Clinical	Community	Teaching
Community	Teaching	Clinical
Teaching	Clinical	Community
Research	Clinical	Teaching

IV. Within each of the functional areas it is possible to conceptualize career progression patterns.

A.

Teaching	Clinical
1. Inservice and outside opportunities	1. MHCS / Psychology Service (clinical slot) (small hospital)
2. AHS/Basic Branch Schools	2. MHCS / Chief, Psych Svc (Chief, Psych Svc) (med. hospital)
3. West Point/Career Branch Schools	3. MHCS* / Chief Psychology Svc (Chief MHCS) (Army Medical Ctr)
4. Internship/Medical School*	
5. Senior Service Schools*	

Area Consultant*

Community	Research
1. MHCS (at training post)	1. At entry in addition to one of other three.
2. MHCS (at TO&E post)	2. Research position at major command level oriented toward clinical/social/industrial research.*
3. Division Psychologist	
4. Organizational Development	
5. Staff Consultant*	

Area Consultant*

* new positions to be developed or expanded.

B. These possible progressions are not meant to be rigid. Any one position could be a multiple position. For example, the community path might lead to a TO&E MHCS slot where the same individual might also be the Chief, MHCS.

C. Individuals would not be restricted to any one path but would follow a predominant path. An individual interested in teaching would seek most of his assignments in teaching positions but could also seek an assignment in a clinical or community position. In fact, this would be encouraged, especially early in his career.

D. While the numbers suggest some degree of advancement they are again not rigid. An individual seeking a career in teaching might have as his final goal the directorship of an internship program or he might seek a position at a senior service school as an end point.

E. An individual seeking to fill an area consultant role could take any predominant path but would also need to have served in the other areas at some level.

F. This system allows an individual to tailor-make his career but in an organized manner. It also allows for more accurate planning of the expansion of psychology in the Army and for more accurate assessment of the need for particular orientations of those recruited to psychology within the Army.

V. Essential to not only this type of career planning but also to the advancement of psychology as a profession within the Army is the necessity for program continuity at both a post and Army wide level. Much of this can be accomplished with available resources.

A. Positions, even within posts, need to be developed and/or identified as falling primarily within one of the career paths.

B. A system for an annual review of the function of each position needs to be developed. One possibility is the submission of an annual report outlining the current activities of psychologists in each position. (Once established, the area consultant could serve as the collection point for these reports). Future assignments could then take into account the programs existing at a particular post and the skills and interests of the individuals available to fill the position.

C. Individuals interested in a particular assignment could then work to develop the skills necessary to fill that position prior to their assignment to it.

D. An attempt should be made to designate reassignments in sufficient time to allow for ongoing correspondence and familiarization between the leaving and arriving parties. The individual currently holding the position could provide by correspondence information about ongoing programs which need to be continued as well as about areas for development of new programs.

VI. Several preliminary recommenations follow from the above report.

A. Permanent committees on career development and planning and the other task areas should be established.

B. Begin evaluating the positions now available in terms of the functional areas and establish some broad descriptions and criteria based on previous assignments.

C. Order the various positions currently existing in terms of the level of responsibility and expertise necessary to fill them and designate entrance positions. Then attempt to establish the hierarchy within each career path through future assignments based on the principles contained in this report.

D. Work toward opening MHCS chief positions to psychologists and not just on an exception basis.

E. Institute the annual report systems as soon as practical.

F. Attempt to increase the visibility of psychologists by encouraging publications in military journals such as "Soldier", "Military Review", and command news letters. (A grass roots campaign to pave the way for development of the new positions suggested in this report).

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REMEDIAL ACTION BY PSYCHOLOGY OFFICERS FOR PERSONNEL RECORDS MAINTENANCE

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Fort McClellan, AL 36201

Psychology officers in the Army are currently confronted with the increasingly obvious problem of not knowing their way around the personnel records arena sufficiently to care for themselves.

Several facts have a bearing on this problem. First, we psychologists have less information in our Official Military Personnel File (OMPF) than do the majority of our contemporaries in rank. Next, we take for granted that forms and reports on us by others are properly submitted and exist where they are supposed to for greatest impact. Thirdly, we may or may not have the opportunity to review these records; but, even if we did, most of us wouldn't know what to look for, how to be critical in what we see, or how to change or update the contents of our file. Four, despite the fact that we strive to seek quality data in our daily practice of our profession, we ignore or think light of data that is obtained on ourselves. Fifth, much of our personal and professional success and survival in the Army depends on the records being properly constituted and maintained. Lastly, we need to increase our efforts in taking care of ourselves in personnel records matters; the responsibility to do so is ours, and psychology officers by and large need assistance in these efforts.

Often one's thinking about personnel matters is guided by a number of false premises. It is not uncommon for psychologists to assume that the Surgeon General Psychology Consultant is "the one and only person whose job it is to watch over these higher level, out of our hands, affairs." We personify the Consultant as the "keeper of the gates within the haven of significant action." Also, we often fall into the trap of presupposing that the people who matter in making decisions about us know how unique a breed we psychologists are. Some of us suspect that it's the Consultant's job alone to promote and present our case or worth to "higher ups" in the system. We even dare say that our Consultant should and can insert a "for your information" memo in each of our files on our behalf at personnel board consideration times. We frequently assume that official-looking orders regarding special assignments to high priority tasks are somehow evaluated and tallied in our favor at Military Personnel Center. And lastly, we erroneously think that we psychologists are the only MSC group of officers who have the personnel cards stacked against us.

What truth exists in this predicament? Unless psychology officers in the field are informed about the ways and means of safeguarding appropriate personnel record keeping, they not only will continue to be anive but they will also take their lumps and fall victims of chance error and selection bias.

The authors, acting as a task-oriented committee at the Current Trends in AMEDD Psychology Conference (December 1974), explored the scope of the difficulties related to personnel records maintenance and suggested recommended actions to fill the information void in our personnel records and to provide a method for checking the accuracy of the current information in the Army personnel system.

Filling the Void

There were at least two general vacuous areas of information that required attention: The specification of psychologists' skills and abilities obtained prior to entry into the service, and the enunciation of our current activities. The authors addressed themselves to the possible ways that these bits of information could be inserted in the OMPF.

Regarding data from prior service, it was first thought that the Psychology Consultant could insert at significant personnel action times a vita or synopsis of the professional training, education, experience we have gained before we donned the uniform. We tested this possibility against our false assumptions, and rejected the notion as unrealistic. We then arrived at the notion of possibly being able to enter into the OMPF this kind of information as a "Certified Document of Professional Training, Education, and Experience." The authors therefore are working on the creation of a format that this input may take and ways that psychology officers may get this or a similar document in their important personnel file.

Information on file regarding the current activities of psychology officers also required scrutiny. What we do on the job may not be cited appropriately. How do we get this kind of representation where it would have the greatest impact? The first idea that surfaced was to organize a list of criteria for the professional development areas in psychology to include items like licensure and certification, publications and presentations, consultative activities, specialty training, organizational membership and chairmanships of committees, adjunct appointments to boards and faculty, to name a few. Entries would include the significant levels within the military psychology role progression models currently being formulated.

Such a list was initially conceived as a resume in code format, profiling competency levels of professional activity in each developmental area, not unlike the medical PULHES profile summary. Thinking that we could initiate yet another profile scheme into the personnel

information system was simply a symptomatic of our egocentric and erroneous belief structure. We were led next to a more reality based idea of modifying the criteria for obtaining changes to the MOS prefix symbol. The prefix, an existing personnel competency designator, would not have to be created, just tempered.

Sizing up our weight of influence even more realistically, we concluded that the present profiling system serves a useful function as is, and that any alteration to its present meaning would be out of synchronization with the rest of the Corps. The authors resolved the issue finally by suggesting the creation of a memorandum to the field (from OTSG level) specifying the areas of professional operations for psychology officers. Such a memo, also citing our educational, training experience, could then be used by psychologists to assist their Raters to understand the areas of activities considered MOS related, professionally consistent, and career desirable by our Branch. The notion being that current activity information justly falls within the Officer Efficiency Report proper.

The Predicament

To digress for a moment, you just would not believe the stack of information that is kept on each of us at MILPERCEN. Looking through your OMPF is an experience, one no doubt which would precipitate an arousal state and maybe even a befuddled one. As you gaze over the seemingly ream of pages, you somehow forget that some especially important paperwork may be in error or incomplete or even omitted. It's not unusual to lose your critical appraisal abilities in such a state of shock.

When you study the folder further and more critically, however, you may find some of the following to be the case:

(a) There may be no official photograph or there may be an outdated one that you submitted many years ago when applying for a commission. Old "mug shots" are no good.

(b) There may not be a properly submitted Academic Report on you. In some cases it has taken nearly two years after graduation for these reports to be posted, and it's not unlikely that your academic community inadvertently submitted some potentially hazardous and derogatory statements on this report.

(c) The academic transcripts included may not have the fact that your degree has been obtained. If you finished your degree work much before your commencement date, the odds are the transcript included in the OMPF does not cite your conferred degree.

(d) What paperwork actions you thought would normally have been initiated by others, according to the Army Regulations that sent you to school, may not in fact have been done.

AD-A143 409 PROCEEDINGS OF THE CURRENT TRENDS IN ARMY MEDICAL SERVICE PSYCHOLOGY HELD..(U) OFFICE OF THE SURGEON GENERAL (ARMY) WASHINGTON D C F H RATH DEC 74 2/2

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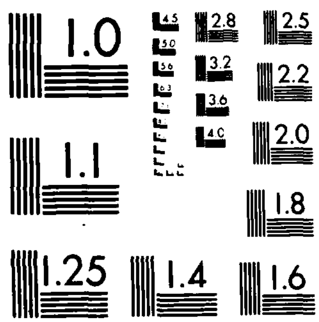

MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

(e) Your MOS may never have been changed from that of a student to Psychology Officer. On the records that count, the MOS designation date may be a year or two post-dated.

(f) You may be eligible for a prefix (or upgrade) to your MOS number. You may have initiated such action yourself. You may think you have attained the proper prefix. After all, Branch may have it in their file! Oddly enough, it may not be in the official file.

(g) Your date of rank may be in error. One of the Psychology Officers had accomplished annual audits of his "local field file" for 8 years. While his DOR was correct at this level of review, his Branch and Military Personnel Center had it posted in error.

(h) You may be missing an OER. The entire time span of your military service must be accounted for in reports of some kind.

Away now from this situational list; how can we plan to circumvent these and similar oversights?

Checking Accuracy

Having addressed the first dilemma of filling the personnel system with new pertinent input, a second set of recommendations were formulated. These pertained to developing a methodology for appraising the authenticity of the current information on us in the OMPF.

First, it is supremely important to make full use of the resource embodied in your local Adjutant General Personnel Officer. He knows his system better than anyone. In fact, it wouldn't be a mistake if you per chance even befriended your neighborhood personnel officer. They are good guys to have on our side. If you weren't aware of it, psychology officers were historically AG also.

The authors, in committee, proposed secondly to design a Check List or road map - like memo to be sent to the field. This effort will list helpful hints to assist psychologists in accomplishing what they have been told to do but often never knew how to begin in records maintenance. In addition to records landmarks and chuckholes to watch for, the proposed memo will refer to current regulations and will provide select resource office phone numbers.

To increase the probability of accurate academic reporting, it was further recommended that Academic Reports be submitted to the OMPF on an annual basis as opposed to that now only initiated at degree commencement time. For some Psychology Officers who spend two to three years on campus, this change would provide helpful evaluations of progress.

Related to this, these annual Academic Reports should be addressed through the Graduate Deans to the Psychology Department Chairmen for evaluative comment.

It should be mandatory that Psychology Officers be provided the opportunity to personally review both their Branch and OMPF files, especially those officers "in the running" for field grade promotional consideration. Since this group is usually small in number, there are a number of relatively economical ways this can be accomplished. For one, the Branch Personnel File, not the OMPF, could be signed out by the Psychology Consultant and brought along upon his sight visitations throughout the year. Another very appealing method would be that the Psychology Services and Division at Walter Reed Medical Center and Institute of Research budget for a dozen or so temporary duty consultation visits by the promotable Psychology Officers in the field. These officers would have had significant experiences to share with the interns and research personnel at these facilities. While on these visits, the field consultants could find the opportunity to personally review their records in nearby Alexandria, Virginia (MILPERCEN). The final way suggested was to have periodic Current Trends conferences sponsored by our Walter Reed colleagues at the site of their activity. Such a plan would also enable a sizeable number of officers to review their files.

Looking Ahead

With the exception of AMEDD, JAG, and Chaplain personnel, officers of other corps are currently filling out Career Progression "dream sheets" and specifying secondary MOS preferences. Our Adjutant General sources say (only hearsay) that even the excepted personnel will be assigned secondary MOS's by their respective branches. If this is in fact going to take place, we need to jump into the decision pathways implementing this Officer Specialty Program on our behalf.

To prepare for this eventuality, the authors are exploring the MOS directory and manuals to find co-related occupational specialties both within and outside AMEDD to appropriately suffice for the secondary MOS requirement.

While our scopes are focused ahead, it just may be the case that other doctoral MSC Allied Science personnel are experiencing similar strains of records maintenance. As our recommendations prove feasible and we are able to traverse the career progression highway more assuredly, we must begin to think about sharing our legitimate routes and means and tactics with our professional colleagues.

Proceedings of Current Trends in Army Medical Service Psychology
December 9 - 13, 1974, Fitzsimons Army Medical Center

NEW DIRECTION IN THE PROCUREMENT OF ARMY UNIFORMED PSYCHOLOGISTS

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There have been recent administrative and economic changes in programs available for procuring uniformed psychologists for the Army. These changes have resulted in the expectation that, in the future, beginning active duty psychologists will, for the most part, have little or no experience with the Army. Under the present system there is little that the prospective uniformed Army psychologist can do to gain an assessment of the Army or for the Army to gain a realistic impression of these same individuals. In order to approach the procurement of uniformed psychologists from a more realistic point of view, with both parties having a better understanding from which to make their decision, a new method of nominating and selecting uniformed psychologists for the Army is suggested. It includes, in addition tot he traditional paper and pencil application, an effort to obtain a more detailed understanding of the candidates while giving the applicants a many faceted view of Army psychology and the facilities, positions, and opportunities available to the uniformed psychologist in the Army. This is accomplished by several methods: greater dissemination of information, personal interviews and on-sight visits by the recruiter, a uniformed psychologist, and the candidate. A committee of uniformed psychologists review the applications of the candidates and makes recommendations to the Psychology Consultant who in turn makes the final selection. Following their appointment newly selected individuals will be assigned a sponsor. This individual, a uniformed psychologist, will aid the new appointee in his orientation and transition into the Army.

The end result is an individual selected because of his orientation, style and interests which are consistent with the needs of the Army. This should allow him to pursue his own interests while providing meaningful input to the organization where he is functioning.

Proceedings of Current Trends in Army Medical Service Psychology
December 9 - 13, 1974, Fitzsimons Army Medical Center

DIVISION PSYCHOLOGY

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Fort Hood, TX

The Division Psychologists' duty assigned to the Mental Hygiene Consultation Service, Fort Hood, Texas, are unique with respect to duty assignment and lines of responsibility. Whereas most Division Psychologists seem to function in a decentralized, divisional mental health care delivery system, the Division Psychologists at Fort Hood (1st Cavalry Division and 2nd Armored Division) are duty assigned to a centralized Mental Hygiene Consultation Service, MEDDAC. At MHCS they are further assigned to the Clinical Psychology Service which is an integral part of the Department of Psychiatry and Neurology. Consequently the role of the Division Psychologist as perceived by the Division Psychologists attending the psychology conference from Fort Hood were dissimilar in many respects to the views held by those Division Psychologists working directly for their respective Commanders, Division Medical Battalions.

The roles and responsibilities of the Division Psychologists at Fort Hood are outlined as follows:

1. The Division Psychologist assigned to the Mental Hygiene Consultation Service may divide his time and responsibilities between traditional clinical roles, community psychology, and command consultation in coordination with the Chief, Psychology Service.

2. The use of divisionally allotted psychologists, assigned to Department of P/N-Clinical Psychology Service, will be determined by the Chief, Clinical Psychology Service, in consultation with both the psychologists and the Chief, P/N. Time spent in Division Consultation Programs will depend on the needs of the Military Community, the needs of the Clinical Psychology Service, the needs of the Department P/N, and the training and interests of the individual concerned.

3. Those psychologists allotted to divisions but assigned to Clinical Psychology - Department of P/N will be directly responsible to the Chief, Clinical Psychology Service and will be rated by that office.

4. Administrative responsibilities will be maintained by division.

No consensus was reached regarding the most effective assignment and utilization of Division Psychologists. However, the work group was in general agreement that roles of the Division Psychologists are contingent upon the organizational structure of the post to which they are assigned.

Proceedings of Current Trends in Army Medical Service Psychology
December 9 - 13, 1974, Fitzsimons Army Medical Center

CONSULTATION TO THE ARMY PSYCHOLOGY PROGRAM

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In discussing the utilization of consultants to the Army Psychology Program, the work group felt it was essential to define consultation. However, in trying to reach a viable definition of consultation, the work group found itself asking the question, "what is expected of the Army psychologist?" The majority of this report, therefore, is addressed to this question.

1. Development of a Comprehensive Philosophy of Army Psychology.

Presently, there is no comprehensive philosophy of psychology in the Army. In order to develop such a philosophy, the following areas need to be explored:

1. The generalist versus the specialist functions of the psychologist. Although psychology training programs have become more specialized, the Army psychologist typically finds himself performing generalist functions.

2. Psychology's relationship to the medical field. At the present time medical personnel are defining the Army psychologist's role (possible exception is the experimental psychologist). Under the present medical influence the focus is on a very narrow aspect of psychological services. It is proposed that psychology not be restricted to the medical field.

3. Psychology's relationship to the military community.

a. Behavior sciences are expanding their role in the military. For example, branch schools are exploring the possibility of having behavioral scientists on their staffs.

b. On military posts psychologists could become involved in establishing and running child care and youth centers.

4. Psychology as a combat function. Efforts need to be made to make psychology relevant to the mission of the Army.

5. Training role. Attention needs to be given to the preparation of psychologists entering the Army to perform as military psychologists.

II. Organizational Structure for the Army Psychology Program.

Under the current organizational structure the following proposals are made:

1. Regional Centers. Regional Centers are conceptualized as a task force of psychologists that could have either a formal or informal structure. With an informal structure, psychologists from various military posts in a geographical area could be assembled to deal with a particular problem. With a formal structure consisting of a permanent task force of psychologists, the Regional Center could serve as an initial assignment for psychologists entering the Army.

2. Exploration should be given to the establishment of a separate psychological service removed from the jurisdiction of medical command. An independent psychological service would help increase the visibility of the psychologist.

NOTE: If a comprehensive philosophy of psychology were developed as proposed above, the organizational structure for psychology would need to be restructured in terms of the philosophy.

III. Current Potential for Consultation.

1. Four psychology consultants available through the Surgeon General's Office.

2. Roster of active duty psychologists. The roster, which is presently being developed, will show the areas of interest and expertise of each psychologist.

3. Procedures for obtaining funding for military/federal and civilian consultants. MAJ Fisburne is investigating this area.

4. Utilization of program review. Peers could be utilized to review existing programs and aid in establishing new programs.

5. Identification of resources:

   a. United States Army Reserve.

   b. National Guard.

   c. Veterans Administration.

   d. Other federal agencies.

   e. Civilian.

AD P003726

...Aviation Medicine
December 9-13, 1974, Fitzsimons Army Medical Center

AVIATOR PERFORMANCE DURING LOCAL AREA, LOW LEVEL AND NAP-OF-THE-EARTH FLIGHT*

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Because of the threat environment in which helicopters will operate, if deployed tactically, there exists the requirement to fly close to the earth. This type of flight has been segmented into three primary profiles. These profiles are defined as:

NOE: Flight as close to the earth's surface as vegetation or obstacles will permit, while generally following the contours of the earth. Air speed and altitude are varied as influenced by the terrain, weather and enemy situation. The pilot preplans a broad corridor of operation based on known terrain features which has a longitudinal axis pointing toward his objective. In flight, the pilot uses a weaving and devious route within his preplanned corridor while remaining oriented along his general axis of movement in order to take maximum advantage of the cover and concealment afforded by terrain, vegetation and manmade features. By gaining maximum cover and concealment from enemy detection, observation and fire power, nap-of-the-earth flight exploits surprise and allows for evasive actions. CONTOUR: Flight of low altitude conforming generally, and in close proximity to the contours of the earth. This type flight takes advantage of available cover and concealment in order to avoid observation or detection of the aircraft and/or its points of departure and landing. It is characterized by a constant air speed and a varying altitude as vegetation and obstacles dictate. LOW LEVEL: Flight conducted at a selected altitude at which detection or observation of an aircraft is avoided or minimized. The route is preselected and conforms generally to a straight line and a constant air speed and indicated altitude. This method is best adapted to flights conducted over extended distances or periods of time.

The most demanding of these profiles is NOE flight because of its unique control and navigation requirements. The aviator who is flying NOE must maintain a high level of alertness to detect and avoid obstacles while maintaining maximum concealment and desired flight path. The aviator acting as navigator has the difficult task of determining aircraft position and giving navigation instructions based on recognition of land marks and terrain feature, in a highly accelerated perceptual world. In many cases he also has the responsibility for monitoring instruments and making necessary radio contacts. Though research has been conducted to demonstrate the capabilities of aviators to perform such flight and the US Army Aviation School conducts NOE training in accordance with appropriate regulations to include Training Circular 1-15, much yet remains to be known about performance in these profiles.

* This paper has been published as USAARL Technical Report No. 75-3.

One area in which quantitative data is needed with regard to NOE flight concerns the problems of flight performance and the stress and workload it imposes on the aviator. The purpose of this investigation was to provide data concerning aviator control inputs per unit time and information about certain aircraft state variables based on measures collected during local area, low level, and NOE flight. No attempt was made to investigate navigation. Though one of the most important factors in this type of flight, it was beyond the scope of this investigation and will be addressed in future research. Physiological parameters measured during the course of this investigation which included muscle activity, heart rate and changes in body chemistry will be covered in other reports.

METHOD

Subjects

Subjects utilized for the present investigation were six experienced rotary wing aviators. Each of these pilots had an average of 2249 career flight hours and had flown an average of 1397.5 of these hours in an aircraft similar to the test vehicle. Of the six aviators, four had extensive NOE flight experience, each having flown an average of 153.75 NOE hours. Two pilots had had less experience with this type of flight.

Apparatus

The test vehicle was a JUH-1H helicopter instrumented to measure and record pilot control inputs and aircraft positions, rates and accelerations. This helicopter inflight monitoring system (HIMS) measures aircraft position in all six degrees of freedom while simultaneously recording cyclic, collective and pedal inputs and aircraft status values. These data were recorded in real time on an incremental digital recorder. A more detailed description of HIMS can be found in USAARL Report No. 72-11.

Procedure

For design purposes the six test subjects were divided into two groups of three aviators each. Each group participated in flight over a two-day period, with each day representing a different test condition. One condition called for an NOE and low level (LL) flight profile and the other required a normal local area flight. These conditions were counterbalanced across the two groups. The procedure on the NOE-LL day required the three subject pilots to be briefed at USAARL after which they were flown to High Falls Stagefield where the testing was begun. Each aviator in turn was requested to enter the right side of the cockpit and prepare for flight. He was then given the following verbal instructions:

"We will take off from High Falls and proceed directly to the course area. We will fly along the course at altitude so you can view the route. While in flight, the flight profile will be explained and you may ask any questions you have about the course. After we finish the run you will be given the controls and will fly back along the course maintaining an altitude of 500 feet MSL and an airspeed of 80 knots. When we reach the end of the course, I will take control of the aircraft and position it on your course heading for the first low level segment of the test. You will be requested to maintain a heading of 021°, an altitude of 200 feet MSL, and a speed of 80 knots for this segment of the test. Upon reaching the end of this flight segment, you will begin the NOE segment of the flight. You will be required to follow the river during this segment, maintaining a track as near as possible to its center. Sustain an airspeed of 45 knots and maintain as close as possible an altitude such that the rotor blades are at or slightly above the trees. This will position the aircraft at approximately 40 ft. above the river bed for the greater share of the course. When we reach the end of the course, land the aircraft. At that time, we will require approximately 60 seconds to check our monitoring equipment and then we shall fly the course again. The course will be flown three times in this manner."

It is recognized that the instructions for the NOE portion of the course did not adhere strictly to the definition of NOE flight. However, such instructions were given so the aviators would be forced to put forth maximum effort to maintain concealment while attempting to complete the course expeditiously. It had been previously established that the entire course could not be completed at an airspeed of 45 knots at an altitude of 40 feet AGL because of its width and winding path. However, such constraints would force the aviators to make airspeed and altitude tradeoffs in an attempt to maintain maximum concealment while trying to complete the course as quickly as possible.

The subject was then given a chance to ask any questions about the course or the procedures to be followed. The familiarization runs were then begun. On the first run the safety pilot flew the straight line course at 500 feet MSL and 80 knots. During this run the subject pilot was able to view the river area and ask questions. When the start of the course was reached the subject was given the aircraft and was allowed to fly a run at the same altitude and airspeed to familiarize himself with the aircraft. Upon reaching the end of the run, the subject was required to begin the first low level segment of the familiarization run. This segment was followed by his first run down the river. After these flights were completed, three flights by the subject were recorded. Each flight consisted of a low level segment and an NOE segment. Total flight time for these three runs was approximately 34.5 minutes. On the average the NOE segment of the flight required 7-8 minutes and the low level segment took approximately 2.5 minutes.

The local area flight which took place on another day of testing required each pilot to fly a straight line course at an altitude of 1000 feet MSL and an airspeed of 80 knots, for approximately 30 minutes. Baseline data directly comparable to the NOE-LL phase of the study were collected on this flight.

Data Collection and Analysis

Continuous information from twenty pilot and aircraft monitoring points was recorded for all flights. A list of these parameters is included in Table 1. This table also lists the derived measures which can be obtained from the recorded parameters. All of these measures, however were not obtained for the present study. Based on judgments made during previous pilot work, it was decided that concentration would be placed on a limited number of parameters. Eight parameters were utilized. Aircraft parameters were pitch, roll, heading, radar altitude and airspeed. Parameters measuring pilot performance included cyclic movements (fore, aft; left, right) collective, and pedal movements.

TABLE 1

Parameters Measured and Derived Measures

Parameters Measured	Derived Measures
Pitch	Pitch Rate
Roll	Roll Rate
Heading	Rate of Turn
Position x	
Position y	Ground Speed
Acceleration x	
Acceleration y	
Acceleration z	
Roll Rate	Roll Acceleration
Pitch Rate	Pitch Acceleration
Yaw Rate	Yaw Acceleration
Radar Altitude	Rate of Climb
Barometric Altitude	Rate of Climb
Airspeed	
Flight Time	
Rotor RPM	
Throttle	
Cyclic Stick (Fore-Aft)	Control Position, Absolute Control
Cyclic Stick (Left-Right)	Movement Magnitude, Positive Control
Collective	Movement Magnitude, Negative Control
Pedals	Movement Magnitude, Absolute Average
	Control Movement Rate, Average Positive
	Control Movement Rate, Average Negative
	Control Movement Rate, Control Reversals,
	Instantaneous Control Reversals, Control
	Steady State, Control Movement.

Inasmuch as the LL flight took approximately 2.5 minutes, a similar time block for comparative purposes was extracted from the other flight segments. To ascertain if time effects were present, this was done for the first and final runs for each subject. These samples were matched in accordance with time so that they represented simultaneous periods during the profile for both runs. Inspection of the data showed that these short segments for NOE and local area flights were representative of the total flights for these profiles.

TABLE 2

Parameters Utilized

Parameter	Statistics
Pitch	Maximum Values
	Minimum Values
Roll	Maximum Values
	Minimum Values
Heading	Maximum Values
	Minimum Values
Airspeed	Mean
	Standard Deviation
Radar Altitude	Mean
	Standard Deviation
Cyclic Stick (Fore-Aft)	Mean Time Steady States
Cyclic Stick (Left-Right)	Mean Duration Control Movements
Collective	Magnitude of Control Movements
Pedals	Frequency of Control Movements

Table 2 presents the parameters and the measures derived for each. It can be noted that minimum and maximum status values across these flight segments were obtained for the pitch, roll and heading parameters. These values were computed by checking each sampled value for the complete 150 second segment and determining its relation to previous values sampled. Means and standard deviations were obtained for radar altitude and airspeed. These values were computed by utilizing all sampled data for the flight period and applying the following mathematical formulae:

1. Mean = $\bar{X} = \sum_{i=1}^{n} \frac{Xi}{n}$ where Xi is equal to each sampled status value and n is equal to the total number of samples in the flight segment.

2. Standard Deviation = $\sqrt{\frac{\Sigma X^2}{n} - \overline{X}^2}$ where ΣX^2 is the squared sample values summed over the flight segment and $\overline{X}^2$ is the squared mean of all samples.

Pilot inputs to controls were treated somewhat differently than the previously discussed measures in that six measures of each parameter were derived. In considering these measures it is necessary to define three key terms. First, in obtaining measures on these controls, it was decided that a steady state occurs when a control has not exceeded an empirically defined distance in a specified time. Second, a control reversal occurs any time a control changes direction. Finally, a control movement was defined as any movement starting from a steady state or control reversal and ending with a steady state or control reversal. Using these established criteria, means were computed from all sampled values for magnitude, duration and rate of control movements and mean time for steady states. The totals for number of steady states and control movements were also recorded. Table 3 presents the times and distances which were utilized as criteria delineating movements in these controls.

The distance ranges were established by determining the minimum perceived control movement for the directions of concern which were thought to yield airframe movement independent of time. The times were established by taking one-half the minimum time it took to move the various controls through the distance ranges previously established.

TABLE 3

Baseline Times and Movement Limits for Controls

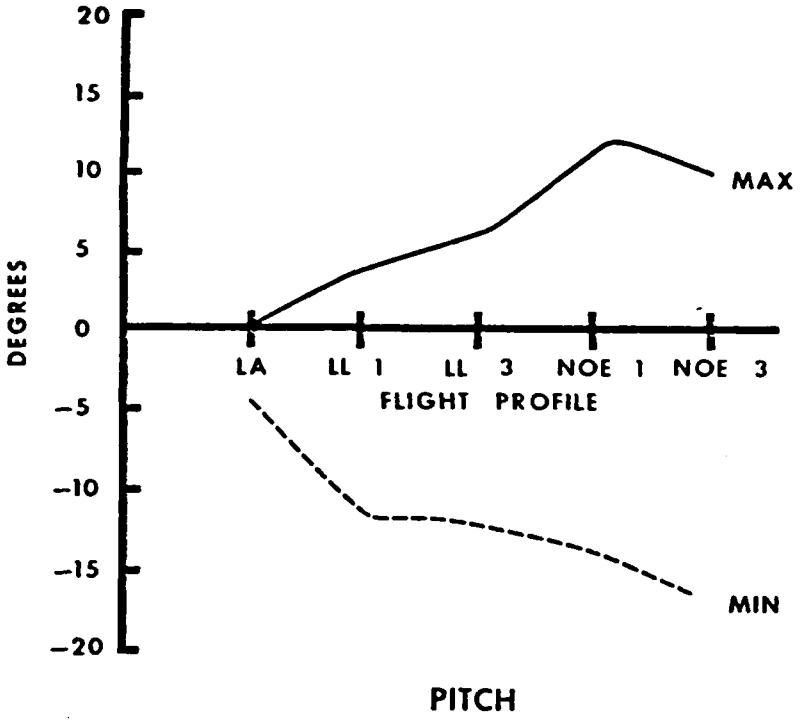
	CYCLA	CYCLR	COLL	THROTTLE	PEDAL
Time durations in seconds	.25	.15	.45	.50	.50
Movement limits in inches	.37	.32	.35	.50	.35

RESULTS AND DISCUSSION

Preliminary analysis revealed no differences across the three recorded NOE flight segments. Also, data were found to be similar across all LL segments. Because of these findings only data from the first and last segments of each type profile will be presented.

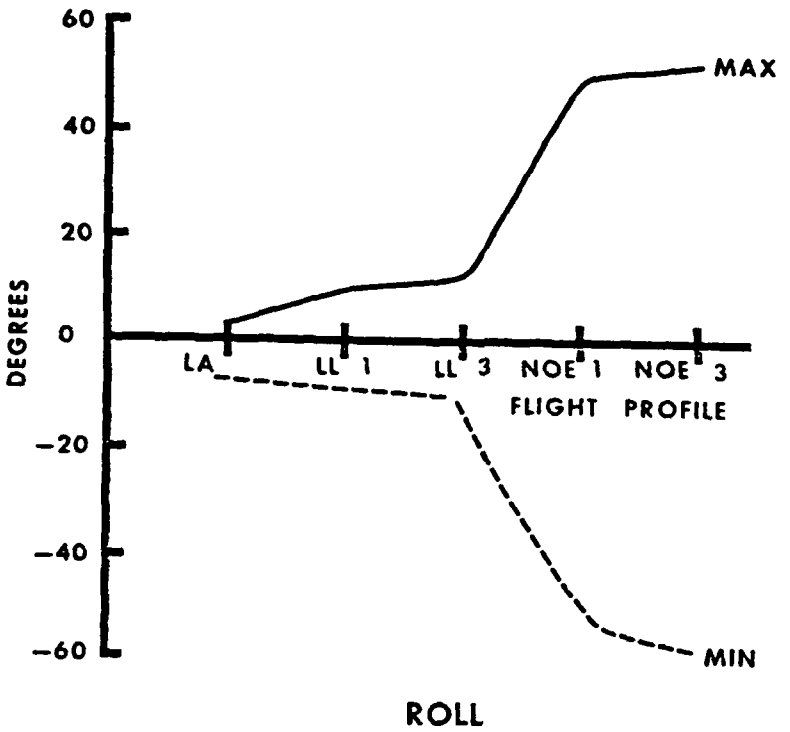
Graphic presentations of mean minimum and maximum values for pitch and roll for all subjects over the flight profiles are presented in Figures 1 & 2. Comparing mean degrees of pitch across flights, it can be noted that the large variations in the range of this measure occurred

during the NOE and LL flights as opposed to the local area control flights. Further, increases in the degree of pitch both maximum and minimum, are extremely pronounced for the NOE flight segment. The same trend is in evidence for the roll measure. For the local area and low level flights, a small amount of roll was measured but in the NOE flight segments where numerous turns were necessary, roll in these turns very nearly reached the operational limits of the aircraft.



PITCH

Figure 1



ROLL

Figure 2

Figure 3 presents the maximum range of the heading values for each flight. It can be seen that large changes in heading occurred with the NOE profile while there were considerably smaller variations with the local area and low level flights. This result is not surprising when consideration is given to the differences in the physical configurations of the courses flown. Both the local area and the low level courses could be considered straight line courses.

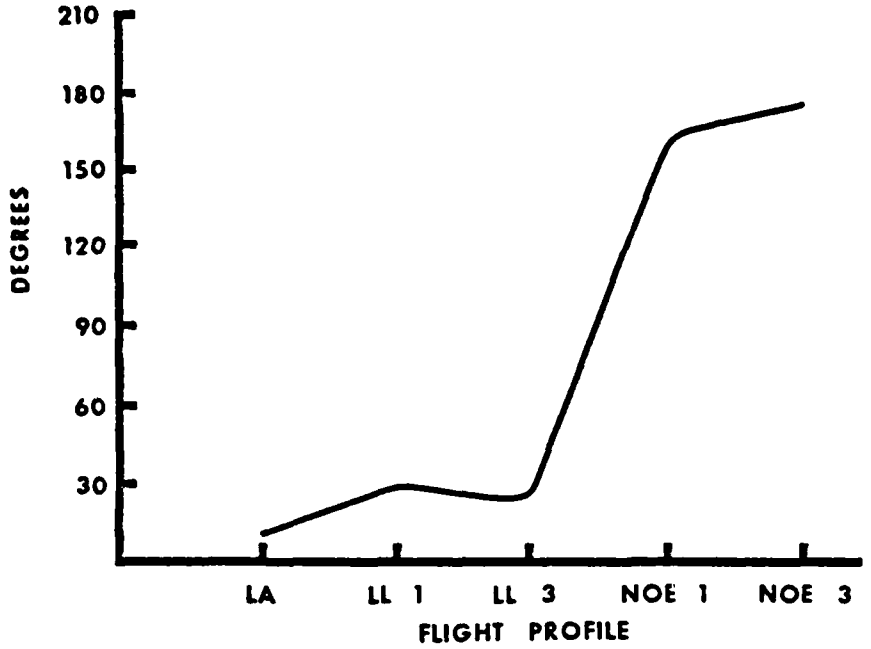
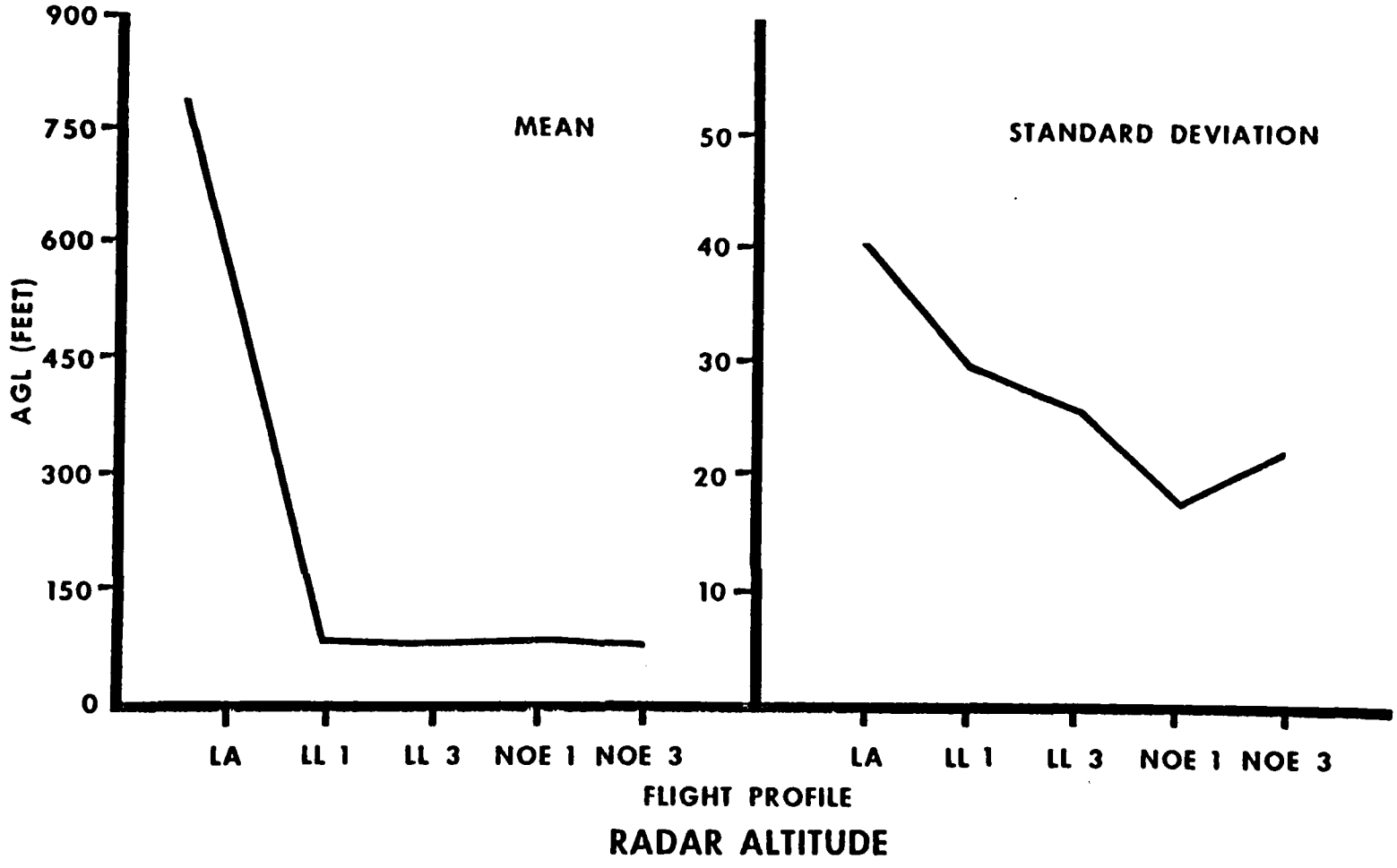


Figure 3

Figures 4 and 5 are graphic representations of the means and standard deviations for radar altitude and airspeed. Referring to Figure 4, it is apparent that altitude was more variable for the local area and low level than for the NOE flight. Considerable variation in this measure again serves to illustrate the different requirements of each mode of flight. With the low level and local area modes, altitude may vary to a greater degree than would be allowed when pursuing a tactical NOE profile where concealment of movement is important.


900
750
600
450
300
150
0
AGL (FEET)
MEAN
50
40
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20
10
STANDARD DEVIATION
LA
LL 1
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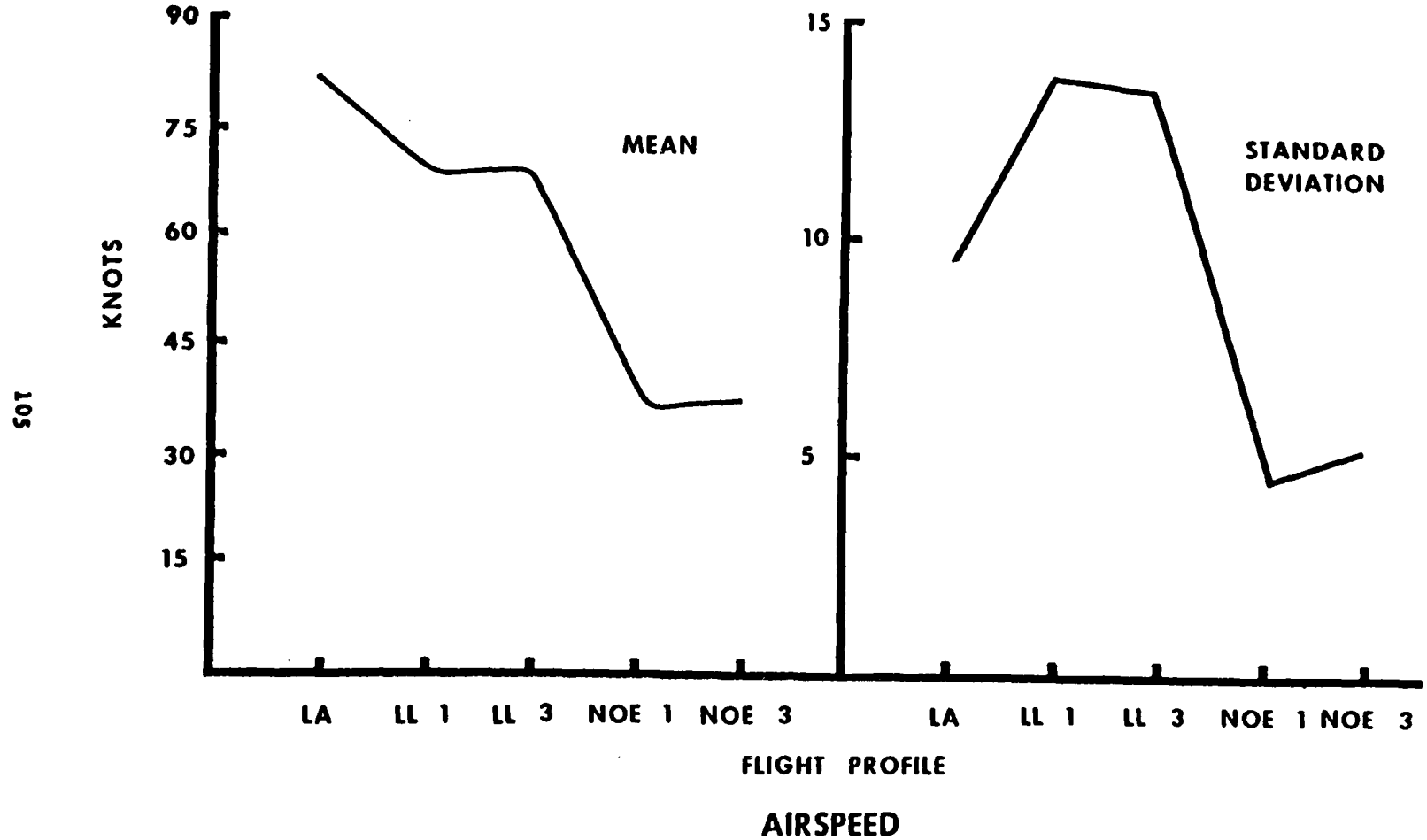
NOE 3
LA
LL 1
LL 3
NOE 1
NOE 3
FLIGHT PROFILE
RADAR ALTITUDE

Figure 4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NOE 3
LA
LL 1
LL 3
NOE 1
NOE 3
FLIGHT PROFILE
AIRSPEED

Figure 5

The different requirements for each type of flight are reflected also in the airspeed measure. In Figure 5 it can be seen that airspeed, although maintained at a higher rate for low level flight was more variable than for the NOE condition. The probable cause of this result could be that in order to negotiate the NOE course it was necessary to maintain the slowest possible speed while still allowing enough forward airspeed for reasonably safe flight.

The results presented thus far would seem to indicate that the NOE requirement then, creates a situation where the aviator attempts to maintain as low and as constant an altitude as possible to avoid detection while at the same time reducing and then maintaining his forward velocity at a point where he can safely avoid obstacles and negotiate the required course.

The large differences reflected in these previously discussed measures would seem to adequately demonstrate that the requirements of pilot and aircraft are both different and more intense for NOE flight than the other two flight modes. If this is indeed the case, pilot performance as measured by control inputs during aircraft flight should also reflect differences.

Figure 6 is a histogram depicting the mean durations of time during which the various aircraft controls were held in steady state during flight. On every control parameter considerably more time was spent in steady state during the local area flight condition than the other flight modes. The NOE condition resulted in an almost negligible amount of steady state time during a flight.

When these data are compared with the mean times for control movements presented in Figure 7, it can be seen that an increasing amount of time is spent in movement between local area, low level and NOE flights. Similarly, the magnitude of these movements also follows this same trend.

In Figure 8, mean magnitude of movement in inches is plotted for all flight modes. It is of interest to note that movements for the control required to fly the NOE course are considerably larger than the local area or low level flight modes. Thus, both the amount of time spent in movement and the size of the movements for all four control parameters are much larger for the NOE condition.

Frequency of movement of controls was also plotted for each flight condition. A histogram of these data is presented in Figure 9. In the case of frequency as with magnitude of movement and time necessary for movement, a larger number of control responses were found for the NOE flights.

Although the feasibility of nap-of-the-earth flight and low level flight is well established, little quantitative data about the actual

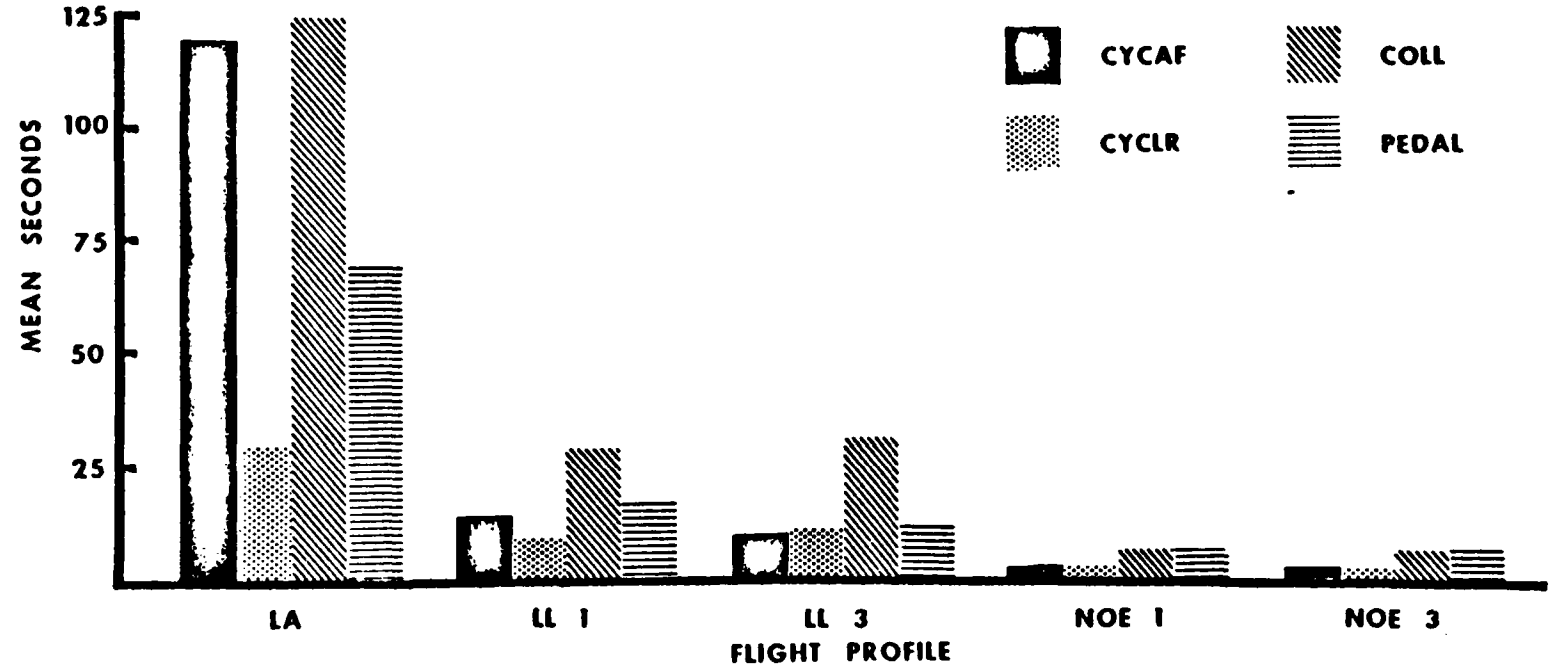
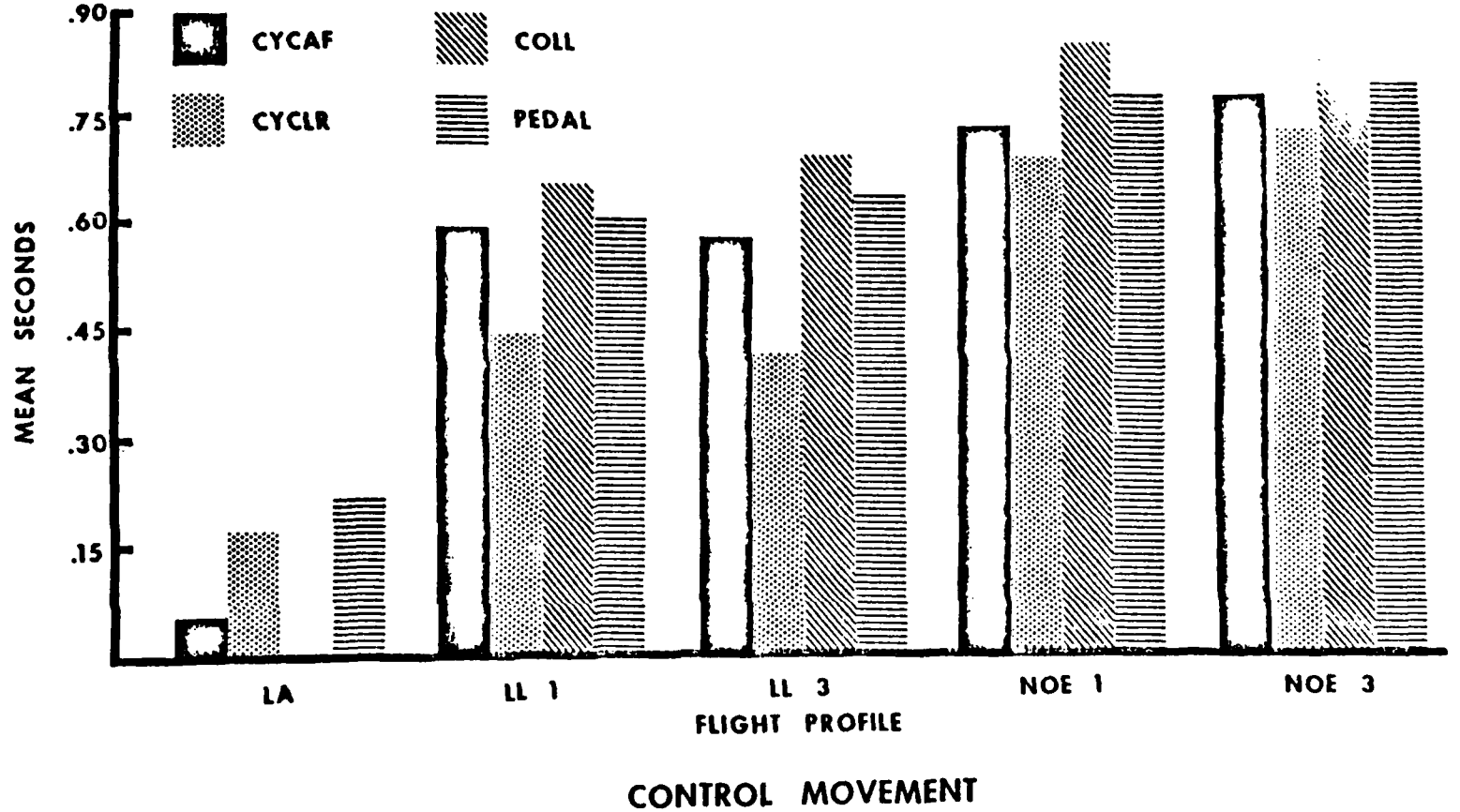

125
100
75
50
25
MEAN SECONDS
CYCAF
COLL
CYCLR
PEDAL
LA
LL 1
LL 3
NOE 1
NOE 3
FLIGHT PROFILE
STEADY STATE

Figure 6


.90
.75
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MEAN SECONDS
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CYCLR
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PEDAL
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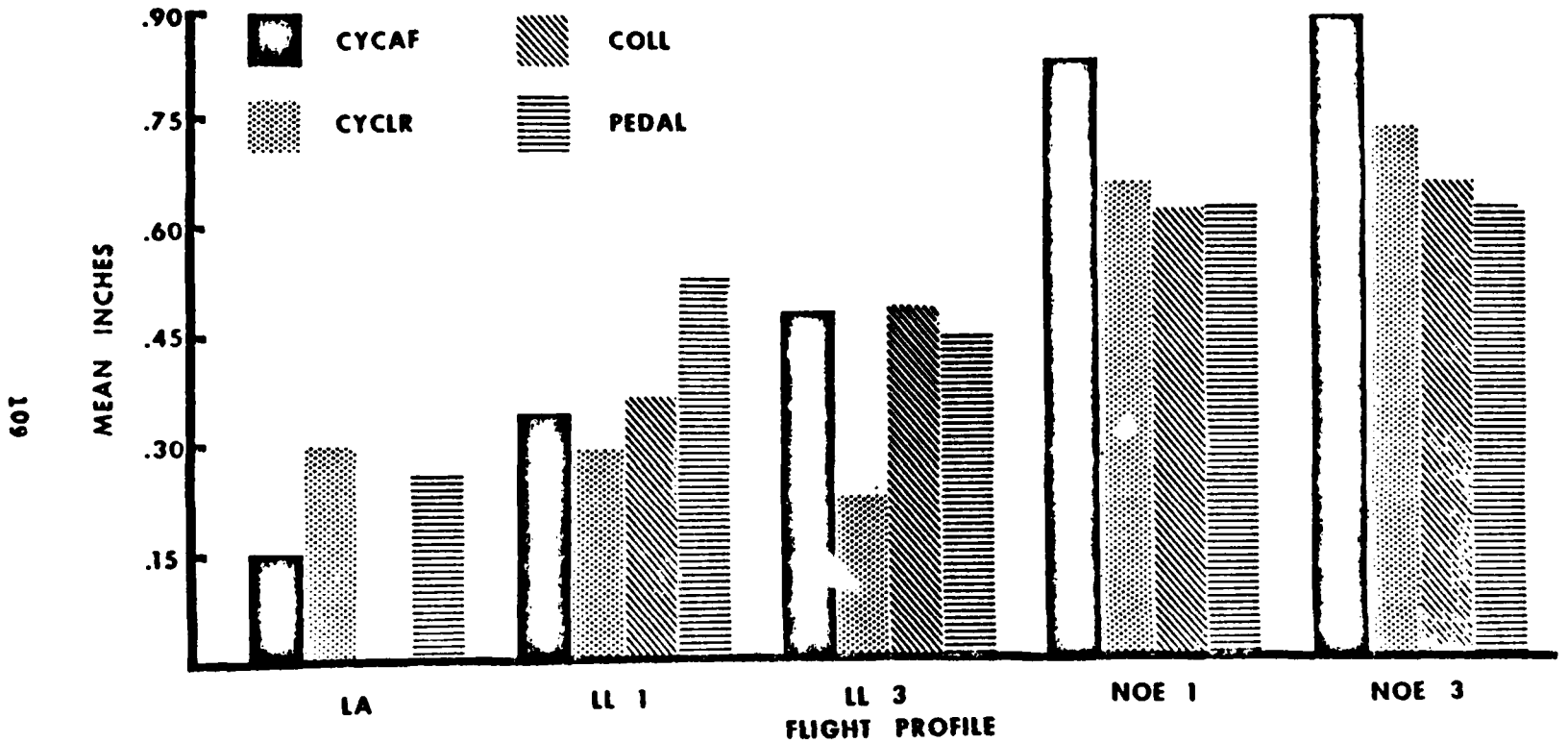
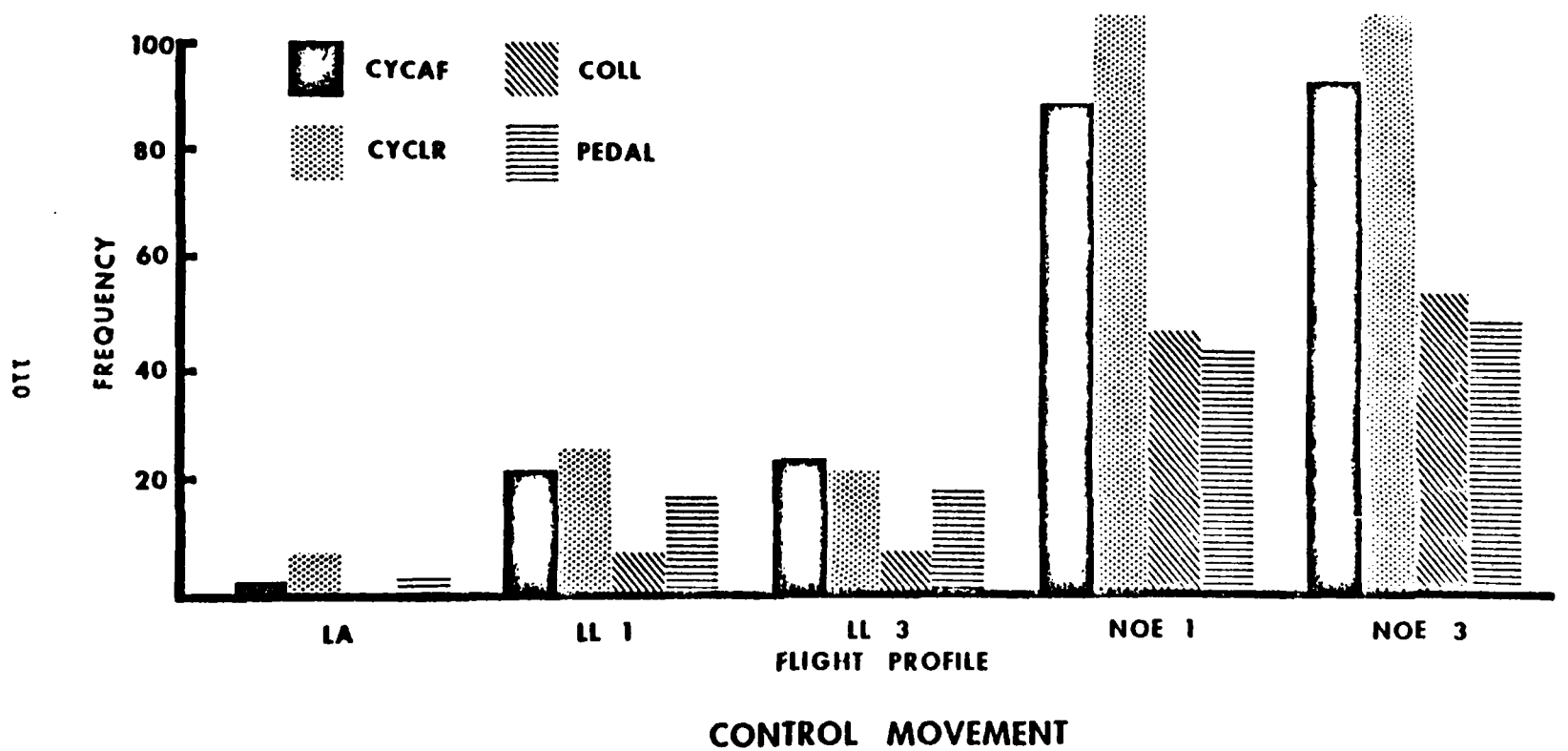
LL 3
NOE 1
NOE 3
FLIGHT PROFILE
CONTROL MOVEMENT

Figure 7



CONTROL MOVEMENT MAGNITUDE

Figure 8


100
80
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40
20
FREQUENCY
OTT
CYCAF
CYCLR
COLL
PEDAL
LA
LL 1
LL 3
NOE 1
NOE 3
FLIGHT PROFILE
CONTROL MOVEMENT

Figure 9

performance of the aviator and aircraft in this type flight is currently available. This research was conducted in an effort to gain some baseline data in this regard.

It is apparent from the data reported that NOE flight places more demands on both crew and aircraft than the other flight profiles investigated. The much accelerated and constantly changing flight environment which the aviator is operating in during this type of flight requires rapid perceptual judgments and similar rapid while extremely precise control responses. Further, this mode of flight, unlike normal flight conditions where adequate time can be allotted to various crew tasks, requires continual multi-task coordination. As a consequence, it seems that a degradation in the performance of this type of flight would occur if conducted over extended periods of time. Analysis of the data collected during the present work, however, did not reveal any such performance differences between first and final NOE flights. Control inputs by all aviators remained the same and aircraft parameters were also quite similar. This, perhaps, should not be unexpected for the time spent on flight task was relatively short and there was a brief break between flights. It will be recalled that the NOE flight segment lasted approximately 7 minutes after which the aircraft had to be landed for a brief period of time. Any flight consisting of the low level and NOE segments only required approximately 10 minutes, 30 seconds. It can be hypothesized that this brief period may have provided a sufficient period of rest between flights to nullify observable fatigue effects. Had continuous flight been possible over longer periods of time, performance degradation as a result of fatigue may have been a factor. It also must be remembered that the pilots in this experimental situation were performing only a part of the task required in a tactical NOE mission. In order to assess only the aircraft handling requirement, these pilots were just required to operate the aircraft and had no communication or navigation tasks placed upon them. Further, it was considered necessary that they familiarize themselves by observing the course before they flew it. These conditions are not likely to exist when a normal NOE mission is performed. The addition of these tasks will be a critical factor and will necessarily demand more from the aviator. This work has provided data which has demonstrated the uniqueness of the NOE flight profile and provided some baseline data. Further efforts are being conducted to provide additional information relative to aviator performance in this type of flight.

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